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ABSTRACT

This report describes some models for effective community-wide cooperation in AIDS prevention and education for African American youth. Since 1994, the Joint Center for Political and Economic Studies has hosted forums around the country to provide information to black public officials about HIV/AIDS prevention education in schools. Forums in Oakland, California; Detroit, Michigan; Memphis, Tennessee; and Durham, North Carolina made clear the complexities of providing culturally competent and effective HIV/AIDS prevention education to African American youth. This report details approaches to providing youth with HIV/AIDS prevention messages that can save their lives. Each of the four forums is briefly described as a prototype for conducting outreach to leadership groups, followed by a description of the general steps undertaken to organize the forums. Other approaches that came to the attention of planners as a result of the forums are also described, as are the many and varied issues raised in conjunction with providing HIV/AIDS prevention education in local schoo s. The report concludes with recommendations based on both the issues and approaches addressed. Three appendixes include: HIV/AIDS and African American youth factsheets; FOCUS articles on HIV/AIDS; and evaluation forms from the Durham forum. (SM)

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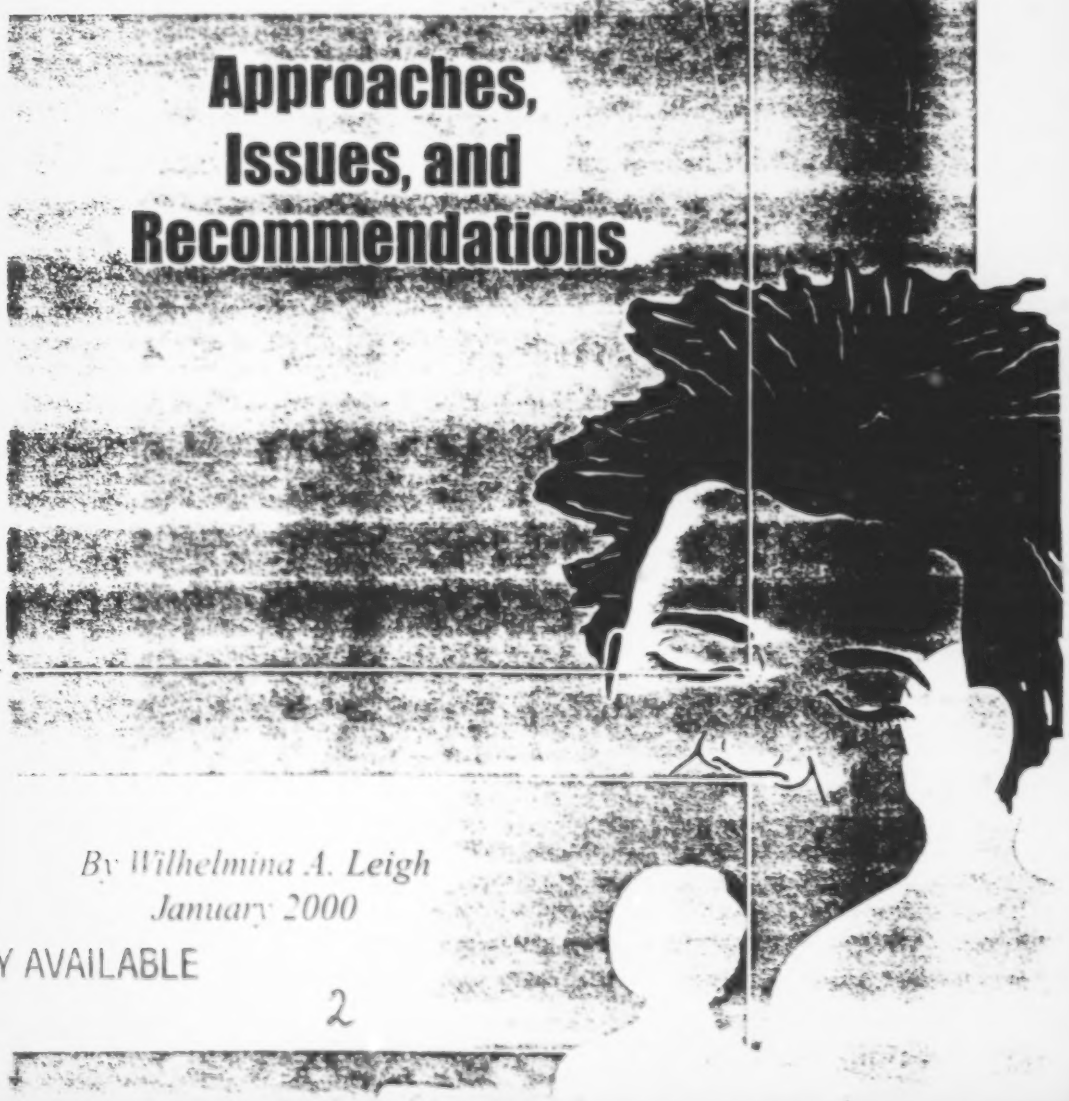
HIV/AIDS Prevention Education for African American Youth:

Approaches, Issues, and Recommendations



By Wilhelmina A. Leigh

January 2000

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HIV/AIDS Prevention Education for African American Youth: Approaches, Issues, and Recommendations

by

Wilhelmina A. Leigh

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Joint Center for Political and Economic Studies

January 2000

The Joint Center for Political and Economic Studies informs and illuminates the nation's major public policy debates through research, analysis, and information dissemination in order to: improve the socioeconomic status of black Americans; expand their effective participation in the political and public policy arenas; and promote communications and relationships across racial and ethnic lines to strengthen the nation's pluralistic society.

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PREFACE

Medical researchers have begun to make significant headway in the treatment of AIDS and its associated virus, HIV, and some populations have changed their high-risk behavior to lower their rates of infection. But unfortunately, good news has not yet arrived in black communities, where AIDS remains at epidemic levels. In spite of the gravity of the situation, many African American leaders remain uncomfortable addressing this serious issue.

Since 1994, the Joint Center for Political and Economic Studies has been providing information to African American leaders and to other policy influentials on the prevalence of the disease in our community, on the importance of persuading people to change risky behaviors, and on the need for additional funding for research and treatment. With funding from the Centers for Disease Control and Prevention, the Joint Center sponsored a series of regional AIDS forums in Detroit (MI), Durham (NC), Memphis (TN), and Oakland (CA). Of particular concern to those at our forums was the need for more effective approaches to reach teenagers before they begin practicing high-risk behaviors. The forums highlighted prevention approaches in a variety of settings and brought together participants from many backgrounds — including health, education, religion, social services, and government. We found that models for effective community-wide cooperation in AIDS prevention and education do exist and can be successfully replicated.

This report describes some of those models, as well as several strategies for replicating the forums themselves. The forums were mainly conducted by Senior Research Associate Dr. Wilhelmina A. Leigh, the manager for this project, and Dr. Bailus Walker, the then-director of health policy at the Joint Center. The tasks could not have been accomplished without the hard work of the site liaison committee members and others who assisted them. The role of the program review panel, likewise, should not be overlooked. The panel's feedback on the forum materials was always valuable and timely. We are deeply grateful for the efforts of these key contributors.

The Joint Center appreciates the five years of support provided by the Division of Adolescent and School Health in the Centers for Disease Control and Prevention and the National Education Association-Health Information Network, which enabled us to host the forum series. We are also grateful to the Kaiser Family Foundation for supporting the publication of this document as part of a Joint Center project on HIV/AIDS and African American Leadership. Kaiser's support allows us to continue disseminating critical information on a challenging health crisis.

Eddie N. Williams
President
Joint Center for Political and Economic Studies

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INTRODUCTION

HIV infection and AIDS have become critical health issues for the youth of this nation. One in every four new HIV infections occurs among people under the age of 20. The estimated 40,000 to 80,000 Americans who become infected with HIV each year represent 110 to 220 infections per day, of which between 27 and 54 are among youth.[1]

African American youth are disproportionately affected by both HIV infection and AIDS. Although black non-Hispanics ages 13 to 19 account for about 15 percent of all youth in this age group,[2] between 1981 and June 1998, they accounted for 66 percent of all cases of HIV infection diagnosed among all youths in this age group.[3] This 66 percent averages the 57 percent that black non-Hispanic males report of all cases of HIV infection among male teens and the 73 percent that black non-Hispanic females report of all cases among female teens.

Similarly, black non-Hispanic youth accounted for 48 percent of all cases of AIDS diagnosed among 13-19-year-olds during this same period. Black non-Hispanic males reported 37 percent of all AIDS cases among all male teens, and black non-Hispanic females reported 66 percent of the cases among female teens. Rates among out-of-school African American youth are similarly high. Among youth ages 16 to 21 enrolled in the Jobs Corps between 1990 and 1996, overall HIV infection rates were more than 2 per 1,000 population; the rates among African American women exceeded 5 per 1,000.[4]

With no cure for HIV infection, it is vitally important to arm youth with knowledge that can limit high-risk behavior and, therefore, their exposure to the disease. Toward this end, since 1994, the Joint Center for Political and Economic Studies has hosted forums around the country to provide information to black public officials and, thereby, enhance their support for HIV/AIDS prevention education in local schools. This project is one of a growing number of community-level prevention approaches in the HIV arena which operate under the premise that involving and mobilizing credible members of a population to endorse and deliver prevention messages will be effective.[5] The target group of black public officials included, but was not limited to, state elected and appointed officials, school board members, city council members, and key administrative staff for these officials.

This project was supported by a five-year (March 15, 1994 to March 14, 1999) cooperative agreement between the Division of Adolescent and School Health (DASH) in the Centers for Disease Control and Prevention (CDC) and the National Education Association-Health Information Network (NEA-HIN). The project was born of dual awarenesses. The first is that prevention is the single best tool to combat HIV infection and AIDS. The second is that inroads against the spread of the disease can be made by targeting prevention messages to African American youth, because they become infected at greater rates than other youth. To work toward the goal of providing culturally competent HIV/AIDS prevention messages for African American youth, the project chose to foster advocacy for HIV/AIDS prevention education in schools among black public officials.

The project forums in Oakland, CA (1995), Detroit, MI (1996), Memphis, TN (1996), and Durham, NC (1997) made clear the complexities of providing culturally competent and effective HIV/AIDS prevention education for African American youth and highlighted the fact that our approach was only one of many. Effective prevention education must involve a range of individuals (parents, teachers, and public officials) and the institutions (school boards, city councils, and state legislatures) within which they work and with which they interact. The insights and information gained from discussions with the many people whom we met and with whom we worked in these four places allowed us to air a wide range of issues.

This report details our approach to working toward the important goal of providing youth with HIV/AIDS prevention messages that can save their lives. Each of the four forums is briefly described as a prototype for conducting outreach to leadership groups, followed by a description of the general steps undertaken to organize these forums. Other approaches that came to our attention as the result of the forums also are described, as well as the many and varied issues raised in conjunction with providing HIV/AIDS prevention education in local schools. The report concludes with recommendations based on both the issues and approaches addressed.

To involve black public officials as advocates for HIV/AIDS prevention education in schools, the Joint Center hosted forums to share with these leaders general information about the disease and to discuss issues associated with prevention education. At four sites (Detroit, MI; Durham, NC; Memphis, TN; and Oakland, CA) the Joint Center worked toward this end with target groups of black public officials, including school board members, city council members, mayors, and their officials key administrative.

Although it is a nonpartisan, nonprofit (501-c-3) organization based in Washington, DC, which provides outreach to black leadership groups as part of its mission,[6] the Joint Center found it challenging to organize forums in places far removed from the nation's capital. Being an outsider organization offers the advantage of enabling one to raise issues that residents might be reluctant to raise themselves concerning events and circumstances in their own backyards. However, the distance between Washington, DC, and the forum sites necessitated extra steps in the planning process that locally based groups would not have to take. Details are provided below about the individual forums and about the general approach used to organize them.

The Forum Prototypes

The organizational nucleus for each of the four Joint Center forums differed enough that we saw in each a prototype for this form of outreach activity. Table 1 summarizes the organizational techniques and outcomes noted for the prototypes, while greater detail for each is provided below.

Model I: Local Foundation

The first forum, entitled "HIV/AIDS and African-American Youth: The Role for Leadership," was held in Oakland, CA, on Thursday, June 29, 1995 (noon to 3 pm). The Oakland forum built upon the momentum and communitywide commitment to address HIV and AIDS issues that then-Mayor Elihu Harris had marshaled at a luncheon for community leaders and others from throughout the East Bay the previous year (April 1994). The mayor's regionwide gathering had led to the establishment of the East Bay AIDS Foundation (EBAF), a community foundation whose goal is to become a resource for groups serving people with HIV/AIDS. The Joint Center's Oakland forum was organized by working with the staff of the EBAF to structure an event that key players in the East Bay would want to attend. This forum therefore can serve as a prototype for outreach orchestrated through a local foundation.

With the advice and guidance of the EBAF, the Oakland forum was planned after one site visit to Oakland by Joint Center staff. To avoid conflicts and to maximize attendance, a date was picked and checked against the local calendar of AIDS-related events maintained by the Alameda County Department of Health. (Oakland is in Alameda County.) The EBAF staff suggested speakers and shared with the Joint Center a list of leaders throughout the East Bay, who subsequently were invited to the forum. Speakers at the forum — an early afternoon event beginning with lunch and followed by presentations — included elected officials and representatives of the medical community and the school system. A moderated discussion session followed the presentations, and a facilitator synthesized the points raised during the discussion. The forum attracted 50 attendees and was held in Preservation Park, a neighborhood in downtown Oakland whose Victorian houses the city has helped rehabilitate.

Model II: Health Department and Local Liaison Committee

The second forum, entitled "Health Issues for African-American Youth: The Role for Leadership," took place in Detroit, MI, on Monday, February 12, 1996 (noon to 3 pm). The Detroit forum was the first

Table 1. HIV/AIDS Prevention Education Forums Organized by the Joint Center for Political and Economic Studies — At a Glance

	Oakland, California June 29, 1995	Detroit, Michigan February 12, 1996	Memphis, Tennessee March 9, 1996	Durham, North Carolina October 3, 1997
Prototype	Organized with assistance from the East Bay AIDS Foundation and office of mayor	Organized by local liaison committee based in Detroit Health Department and chaired by its director	Organized by local liaison committee chaired by state representative	Organized by local liaison committee co-chaired by activist physician and state senator
Organizational Technique	Phone calls FAX survey	Phone calls FAX survey	Phone calls FAX survey	Contacts were initiated through North Carolina Central University's Department of Health Education
Structure of Forums	Weekday luncheon event (noon to 3 pm) with meal first, followed by speakers, and a facilitator-led discussion session	Weekday luncheon event (Noon to 3 pm) with meal first, followed by speakers, and discussion period	Saturday event from 9:30 am to 2 pm including lunch. Presentations were followed by working session in which recommendations for future action were developed.	Weekday event from 10 am to 1:45 pm, including lunch. Speakers were followed by session during which consensus statements were discussed and voted on.

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Selected Examples of Effective Initiatives	California Prevention Education Program (CAL PEP) Quilt project within the Oakland Unified School District (OUSD) Peer counselors and educators within OUSD AIDS Project of East Bay — arts activities with youth (Showcase)	Church-based marching and drummer corps for youth Peer counseling within school system Use of school-based health centers	Girls, Inc. program in local schools to reduce teen pregnancy HIV/AIDS ministry based at Mississippi Boulevard Christian Church	Project StraighTalk of Durham City Health Department Teens Against AIDS — St. Augustine's College (Raleigh, NC) The Adolescent Connection (Greensboro, NC)
Forum Attendance and Media Coverage	50 Attendees Press attendance; article in FOCUS	75 Attendees Press and other media coverage (e.g., FOCUS article, radio interview, local newspaper articles)	80 Attendees Press and other media coverage stimulated by press briefing and press releases (e.g., FOCUS article and local newspapers)	180 Attendees Meeting with newspaper editorial boards; coverage both in local and other newspapers and in FOCUS

to be organized using a local liaison committee, which is defined as a group of individuals with differing professional affiliations who live and/or work in a locality, are key players in the local HIV/AIDS arena for African Americans, and agree to advise and work with the Joint Center to plan a well received and well attended forum about HIV/AIDS. Committee members were recruited from among local black leaders with recognized stature in the field of health, in general, and in the area of HIV/AIDS, in particular. Centered at the Detroit Health Department, under the leadership of its then-director Cynthia Taueg, the Detroit local liaison committee enabled us to generate interest in our forum among black leaders in the city and its surrounding communities. Thus, this forum can serve as a prototype for outreach based upon the use of a local liaison committee and with central involvement by the local health department.

In addition to the initial site visit to Detroit, Joint Center staff met once there with the local liaison committee to make plans for the forum. Speakers were recommended and invited by the staffs of both the Detroit Health Department and the Joint Center. These speakers included a medical professional, the school superintendent, a school board member, and a religious leader. In addition, a list of invitees was assembled by the committee. The date and place for the event were dictated by the desire to have the city's mayor (Dennis Archer) make the opening forum presentation. (In his talk, Mayor Archer noted, among other things, the appropriateness of addressing issues related to HIV/AIDS at a forum held two days before Valentine's Day.) The forum, which was attended by 75 people, was held at Cobo Conference Center, a facility near the mayor's office. Local newspapers and other media were contacted by the Joint Center, and several representatives attended the event, ultimately yielding radio interviews and stories in both the *Detroit News* and the *Detroit Free Press*.

Model III: Health Department, State Legislator, and Pastors

The third forum, entitled "HIV/AIDS Among African-American Youth: Developing An Action Agenda for Leaders and Policymakers," was held in Memphis, TN, on Saturday, March 9, 1996 (9:30 am to 2 pm). The planning of this forum also was facilitated by a local liaison committee with input from the local health department. Two distinguishing features of the planning for this forum were the chairing of its liaison committee by an elected official and the hosting of the event in conjunction with a conference for pastors. Chaired by the Honorable Kathryn I. Bowers, a Tennessee state representative, and supported by key staff at the Memphis-Shelby County Health Department (including its director Yvonne Smith Madlock), this local liaison committee attracted to the forum 80 concerned persons from throughout the state of Tennessee. Having State Representative Bowers as liaison committee chairperson enabled us to attract several other elected officials to the event as well.

Because the Joint Center forum in Memphis was held in conjunction with the First Annual Conference on HIV/AIDS Education and Leadership for Pastors, organized by the local African American Church Consortium, the Joint Center-Memphis local liaison committee met several times with the planning group for this conference, as well as on its own. The forum format included a segment on "The Faces of AIDS," featuring youth infected with the disease (identified only as Mary Doe, Jane Doe, and John Doe), who discussed their current life situations and the prevention measures they would recommend. Other presentations were made by the director of the Memphis-Shelby County Health Department, a commissioner on the Memphis School Board, and a physician who treats many of the HIV/AIDS patients in Memphis.

The Memphis forum, held on a Saturday at Mississippi Boulevard Christian Church (as the pastors conference had been), included a working lunch session whose end product was recommendations about education in schools, within the religious community, and in the community-at-large to address the HIV/AIDS epidemic. A press conference at the Memphis-Shelby County Health Department, supplemented by a press release and a media advisory about the forum, resulted in press interviews and numerous articles both in the major Memphis daily newspaper (*Commercial Appeal*) and in local black newspapers.

Model IV: State Legislator, and Private Physician

The final forum, entitled "HIV/AIDS in African-American Youth in North Carolina: The Role of Leadership," was held in Durham, NC, on Friday, October 3, 1997 (10 am to 1:45 pm). This prototype for outreach to black public officials was spearheaded by a local liaison committee co-chaired by an activist physician (Elaine Hart-Brothers, MD, MPH) and a state senator (Honorable Jeanne H. Lucas). The central involvement of both a physician and a state legislator in its planning gave the Durham forum not only a grounding in the medical realities and issues associated with the disease but also a policy orientation similar to that of the Memphis forum.

Among its 180 attendees, the Durham forum attracted numerous federal, state, and local elected officials from throughout North Carolina who addressed the need for action to mitigate the impacts of HIV/AIDS in their communities. In addition, presentations were made about the nature of the disease and how it has affected youth in the Raleigh-Durham-Chapel Hill area, in particular. The forum presentations were prelude to a discussion of three legislative proposals considered, but not enacted, during the 1997 session of the North Carolina General Assembly — comprehensive, coordinated health education; a pilot needle exchange program; and state funding for prevention activities by community-based organizations. The forum culminated with voting on consensus statements for these three issues. All three consensus statements were approved by forum attendees with only one or two dissenting votes (out of the 120 or 121 votes cast). The Durham forum received good media coverage, including numerous interviews, an op-ed piece by State Senator Lucas in the Durham *Herald-Sun*, and articles in other local and national papers, including the *Daily Challenge* (Brooklyn, NY), the *Carolina Times*, the *Duke Chronicle*, and the *News & Observer* (Raleigh, NC).

Organizing forums long-distance without a local chapter or affiliate required developing and adhering to a general methodology. This methodology is detailed below. Steps relevant both to national groups that are organizing forums long- distance and to groups that are organizing events in their own locality are indicated with a ❖, rather than a bullet.

A. Conduct Reconnaissance

Although each of the four forums was distinctive, they all began with the same first step — reconnaissance. Reconnaissance was undertaken to determine the most efficacious way to organize each of the forums, and thus resulted in some of the variation across sites. The reconnaissance and planning activities for this project were constrained by: the need to host the forums in a timely manner; the desire to get attendance and participation by the maximum number of leaders; the desire to host events compatible with the local AIDS environments; and the desire to avoid conflicts (in timing and topics) with other AIDS-related events being planned locally. The major steps are as follows:

- **Develop a list of contacts in each site.** Names were solicited from Joint Center staff of professional contacts and colleagues who were knowledgeable about the community being worked in and who could provide entree to people and other local resources. A list (with addresses and phone numbers) of black elected officials (both state and local) was culled from the Joint Center's *Roster of Black Elected Officials*.[7] Names of contacts also were solicited from and provided by the NEA-HIN for Detroit and Oakland, two sites in which both they and the Joint Center worked.

- **Make introductory phone calls to people on the contact lists.** We phoned individuals on the preliminary contact lists to determine their

RECONNAISSANCE QUESTIONS

A. What are the major issues related to adolescent health and HIV/AIDS among Black youth in your city/metropolitan area?

B. In your city/metropolitan area, who are the major African American public officials (both elected and appointed), school officials, and leaders in community-based organizations? (Please provide names and phone numbers, if available.) Are these people actively involved in the effort to integrate effective HIV/AIDS education into the school curriculum in your locality?

C. What barriers, if any, prevent the black leaders identified in item B from collaborating to improve the health of adolescents in your community and to specifically work to integrate effective HIV/AIDS education into the local school curriculum?

D. Do you know of any health- or HIV/AIDS-related events planned during 1995 and 1996 onto which we could piggyback a session about health issues for black adolescents? (Please provide dates, sponsoring organizations, and phone numbers, if available.)

E. What is the optimal time and place (in terms of getting the best turnout) to hold a training session on adolescent health and HIV/AIDS in your locality? Is it weekdays or weekends? mornings, afternoons, or evenings?

F. Do you think it would be necessary to pair a training session on adolescent health with another activity to attract an audience of locally prominent people? If so, what type of activity do you think would be best — a meal (breakfast, lunch, dinner), a reception, or another health-related event (as mentioned in item D above)?

knowledge about and interest in HIV/AIDS and related issues and their ability or willingness to work with us to host a forum. We also sought referrals to other local leaders/black public officials whom we might not know about, so that we could contact them for the same purpose.

- **Develop a short questionnaire to use with phone contacts.** Questions were developed and sent by facsimile (FAX) to people we were unable to reach after several attempts by phone. These people were contacted later by phone or FAX to seek answers to the questions.

- **Make inquiries about arranging appointments to meet with selected individuals during a site visit.** The purpose of the site visit was to gather additional information and answers to questions about likely community responsiveness to the forum, best timing, and so on. Thus, appointments were sought with a cross-section of mainly local (and some state) officials, including elected officials, representatives of school systems, representatives of community-based organizations and HIV/AIDS service organizations, and health department officials. Meetings with these individuals often yielded additional names and addresses of persons to contact regarding the proposed forum.

The site visit established an initial presence for future planning activities and gave us face-to-face data about the people with whom and the place in which we would be working. Site visits also enabled Joint Center staff to gain the knowledge necessary to assess relationships among the black leaders in each place and strategic information for decisionmaking about how to organize the forums to maximize attendance and avoid local squabbles about turf.

- **Inquire about the statutory context in each locality with regard to HIV/AIDS prevention education.** Each of the four sites differed in the statutory requirements for HIV/AIDS prevention

MANDATES FOR HIV/AIDS PREVENTION EDUCATION IN FOUR SITES

Detroit, MI

The health education and HIV/AIDS prevention curricula for the Detroit school system are guided by the Michigan model. A mandatory personal health management course (including human sexuality and HIV/AIDS prevention education) is offered to 10th graders at 22 of the 28 comprehensive high schools and the 4 alternative high schools in the Detroit school system.

Durham, NC

A statute — North Carolina General Statute 115C-81 (e1) — was ratified on July 29, 1995, which mandates that health education in public schools throughout the state only teach abstinence until marriage. Thus, HIV/AIDS, STDs, abortion, contraception, etc. are not discussed in public schools in NC. Per the 1995 statute, if a majority of parents attend their local school board hearings and voice a desire to have more comprehensive health education provided, the local system must respond to their request. If this does not happen, then abstinence until marriage is the only instruction given relating to health and sexual activity.

Memphis, TN

Since the 1991-1992 school year, local education agencies in all the counties of Tennessee have been mandated by state law to locally devise, adopt, and implement a program of family life instruction in conformance with curriculum guidelines established by the State Board of Education *if* the county pregnancy rate exceeds 19.5 per 1,000 females ages 15-17 (per Senate Bill No. 1144, signed into law on June 8, 1989). The family life curriculum must include a component that specifically addresses the nature of AIDS and sexually transmitted diseases and must be implemented during each of the succeeding four school years following the calendar year in which the qualifying pregnancy rates are reported. Both Memphis and Shelby County currently are required to offer this family life curriculum.

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Oakland, CA

A state law (A.B. 11) mandates HIV/AIDS prevention education in California middle and high schools. In response to this mandate, the Oakland Unified School District (OUSD) has incorporated HIV/AIDS prevention education into two required courses (8th grade science and 10th grade world cultures) since the 1992-1993 school year.

education in its schools. Knowing these requirements made it possible to structure forums to raise the major issues needing to be raised in each locality but within the proper context. Knowing the requirements also can guide the judicious selection of partners with whom to work and can warn of adversaries that may be encountered while developing the forums.

- **Use information gathered (names, phone numbers, etc.) to compile a list of people to invite to the forum and to consider as forum presenters.**

B. Determine the "best" partners with whom to work.

"Best" is defined to mean partners whose involvement with your activity will draw the largest number of people to your event and alienate the smallest number of people. In determining the best partners, one should try to avoid being used to achieve the agendas of others. One way to do this is to select as working partners persons or organizations whose primary goal is the same as yours: to reduce the spread of HIV/AIDS among youth.

- **Base the assessment of "best" partners on the frequency with which a given person is positively referenced.** For example, if you contact five people who do a variety of things with regard to HIV/AIDS in a locality and each of them mentions the same person in a positive way, consider that person a key one to involve in the planning process. Negative comments about an individual should be verified by asking numerous others about the individual so referenced and, to the extent that one can, assessing how both the comment and the individual may be influenced by local politics.

- **Accept the fact that "all politics are local" and that the groups you might think to be pivotal on any issue in any black community might not be key actors in a given locality with respect to HIV/AIDS.** Community perceptions of the leadership and efficacy of historically prominent black groups may vary from place to place. Determine which groups evoke the most enthusiastic responses most frequently among the persons involved with HIV/AIDS issues in each community and consider this when making decisions about working partners. Try to avoid getting caught up in local political squabbles or turf battles that could impede your organizational activities.

C. Establish a local presence.

- **Use a local liaison committee.** As noted above, the local liaison committees used in this project were groups of individuals with differing professional affiliations, who lived and/or worked in a given locality, who were key players with regard to HIV/AIDS education, prevention, or treatment, and who agreed to advise and work with the Joint Center to plan a forum that would be well received and well attended. Committee members generally were recruited from among local black leaders with recognized interest in the impacts of HIV/AIDS on the African American community, or with stature in the field of health, especially with respect to HIV/AIDS. Ask one or two of the liaison committee members to serve as committee chair or co-chairs and be points of contact for quick decisionmaking and action as the planning process moves along. A wisely selected liaison committee can do much to facilitate the long-distance planning of a forum.

- **Associate the event with a local entity that is highly regarded by many.** In Detroit and Memphis, for example, our forums were organized in concert with the local health departments, agencies perceived as being responsive to the local needs stemming from this disease. Having such a local affiliation can simplify the planning process and bolster the outreach for the event. However, because of personalities and politics, in some places it may not be viable to work through any single local entity.

- **If there is no single local institution through which to work, to the extent feasible, work through the place(s) of employment of one or more of the liaison committee members.** For example, in Durham, the co-chairs of our liaison committee were a physician and a state senator. We were able to work through their offices to set planning meetings and organize the event.

- **Leave enough time between establishing a local presence and hosting the forum to develop good working relationships and trust among the working partners.** It is desirable to allow at least six months for this purpose. During this time, the local liaison committee or other planning body would convene, with a representative from the national entity present as necessary, and develop plans and a timetable for organizing the event. Being able to plan over an extended period allows the major doers to become comfortable with one another and to work together more efficiently as a team. Having six months' planning time also would provide flexibility for getting commitments for the place, the food, and the speakers desired for an event. With the exception of Oakland, at least a year elapsed between initial site contact and hosting the forum in each site. The Oakland forum was organized more quickly because we had access to lists and information recently assembled for a very similar purpose by an already established local entity.

D. Be Clear About Resources and Constraints.

- **When recruiting chairpersons for the liaison or planning committee, explain the extent of your financial resources.** Because community-based organizations that work with African Americans around HIV/AIDS and other health issues often are underfunded, a national organization seeking to organize a local forum is likely to be viewed as a potential source of cash for purposes that may not be legitimate under the terms of its project funding. This problem can make it difficult to involve community-based organizations in a major way in the planning of local events and may argue instead for targeting a governmental entity, such as a health department, as a working partner. One way to make use of community-based organizations' expertise and to involve them in the event without necessarily requiring the payment of money to these institutions is to use their representatives as forum speakers.

- **Take advantage of the resources to which liaison committee members may have access as a way to develop a forum that appeals to and attracts the greatest number of people.** For example, the Detroit forum was held at Cobo Conference Center for two reasons. First, the Detroit Health Department could use space there free of charge. Second, because the Cobo Conference Center is across the street from city offices, we could use the convenience of the forum's location to entice the mayor to fit this event into his busy schedule. In Memphis, the Memphis-Shelby County Health Department was working with the African American Church Consortium to organize an HIV/AIDS conference for pastors, a fact that enabled us to use for our forum the church facility where the pastors' conference was held.

- **Use local data and other documents specific to each site at the forum.** For example, data about the incidence, prevalence, and deaths associated with HIV infection and AIDS from local and state

health departments were gathered and used to create fact sheets for distribution at each of the Joint Center forums. **(See Appendix A.)** Fact sheets were helpful because the raw local numbers, representing human lives impaired or lost, made it hard to deny the existence of HIV/AIDS as an issue. In addition, materials produced by our planning partners were distributed at the event. Allowing local groups to leave flyers and reports on a materials table gives the forum more local flavor, encouraging local attendance and participation.

- **Clarify what is to appear where and how on printed materials.** Agreeing on what seems like minor details such as these up front can smooth the road for the planning activities that must take place along the way to a successful forum. For example, the use of certain words and phrases in program materials could attract or repel certain audiences in different localities. Also, contract requirements on the national organization may dictate phraseology to demonstrate that a given objective is being achieved. Inquiring about, learning about, and responding to these sorts of constraints is wise.

E. Let the local planning body determine the particulars for the forum.

- **Let the local planning body determine the name, structure, and content for the forums.** Because of the great variation among localities with respect to the form and substance of HIV/AIDS-related issues, it is critical to let the local planning group determine the shape of the forums, rather than trying to impose a "cookie cutter" mold on them. The selection of titles for the four Joint Center forums is a good example of locally guided variation. The words "HIV/AIDS" did not appear in the Detroit forum title ("Health Issues for African-American Youth: The Role for Leadership"). However, local health department staff made sure that persons interested in HIV/AIDS issues knew the forum's thrust and came to it. In Memphis, the clause "developing an action agenda for leaders and policymakers" was in the title to reflect the afternoon session in which working groups on the topics of education, church, and community would develop action items to present to local leaders and policymakers. The planning group for the Durham event wanted "North Carolina" in the forum title to emphasize the fact that they were targeting a statewide audience, not just Raleigh-Durham-Chapel Hill.

Although the religious community and churches are potential sources of effective HIV/AIDS prevention education, we were guided by our local planning groups in each site in structuring an event to engage this important leadership segment. On the advice of the Joint Center-Memphis Liaison Committee, the Memphis forum did not include any presentations by members of the religious community. The liaison committee had advised us that if we invited a pastor of any single denomination to make a presentation, we also had to invite a pastor of every other denomination active in Memphis to speak, in order to guarantee forum attendance by members of the religious community. While we held the event in a church after a pastors' conference, and several pastors were in the audience, none was an invited forum speaker. The Oakland and Durham forums also lacked invited presentations by members of the religious community, other than to bless the food. For the Detroit forum, however, our liaison committee recommended a pastor who made a provocative presentation about the role of the church in addressing health issues, including HIV/AIDS, among African American youth.

As yet another example, our local planning groups also advised us about the use of persons with HIV infection or AIDS as presenters. In Memphis, one of our liaison committee members felt very strongly that the best way to bring attention to this issue was to use persons with HIV infection or AIDS as speakers. She organized a very compelling forum segment, entitled "The Faces of AIDS," which featured three young people — known only

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as Mary, Jane, and John Doe — who spoke about how they contracted the disease and their subsequent experiences living with it.

- **Take advice from the local liaison committee or other planning group about details such as the venue, time of day, and type of food for the event.** Local residents have the best sense of the types of places, types of food, and times of day that draw the biggest crowds. As noted above in the discussion about resources, taking local advice also can save money or give access to facilities that the community perceives as advantageous. The Joint Center forums were held, variously, on a weekend, on a Friday, two days before Valentine's day, and at the beginning of a month known locally both as AIDS Awareness Month and "Let's Talk (with Teens About Sex)" Month. The local liaison committees suggested these days, dates, and times, and by following their recommendations we attracted large interested audiences to each forum.

- **Consider hosting the forum in conjunction with another related event being held in a locality.** For example, at the suggestion of the Joint Center-Memphis liaison committee, our HIV/AIDS prevention education forum was held on the Saturday following an education and leadership conference for pastors, which was hosted by the African American Church Consortium from Thursday through Saturday morning. Our forum and the pastors conference were held at the same place (Mississippi Boulevard Christian Church), and the Joint Center-Memphis liaison committee met with the planning group for the First Annual African American Pastors HIV/AIDS Education and Leadership Conference (with the theme "Our Neighbor Has AIDS: The Black Church Response") to orchestrate the two events successfully.

  One problem with this kind of bundling is that the sponsors and hosts of each event may encounter difficulty distinguishing their event from the other when seeking to generate interest in it, particularly with the media. The risk of the HIV/AIDS prevention education forum being overshadowed by its predecessor conference can be minimized, however, if the two are advertised as distinct events, as they were in Memphis.

F. Contact media outlets in a timely manner.

Members of our liaison committees in Detroit, Durham, and Memphis, as well as the staff of the East Bay AIDS Foundation and others who helped to organize the Oakland forum, agreed on the desirability of encouraging local media to publicize and cover the event. This includes television as well as newspaper reporting. Once the "who, what, when, where, and why" are set for a forum, contacting a media representative with whom liaison committee members have established relationships can be very helpful. In addition, free public service announcements generally can be obtained for a forum of this nature.

- **Using well-known speakers can bolster the chances that media representatives will attend and report on a forum.** Public officials routinely share their schedules with media representatives, who attend and report on the scheduled events that seem most newsworthy. Having the mayors of Oakland and Detroit at the forums in their respective cities garnered media attendance and coverage for these two events.

- **Consider holding a press briefing.** For example, for the Memphis forum, a press briefing was held at the Memphis-Shelby County Health Department two days before the Saturday event. Representatives of local television stations and newspapers were invited to the briefing. Television spots and an item in Friday's *Commercial Appeal*, the city's major newspaper, stimulated interest in the event and probably contributed to its robust attendance. Subsequent press coverage of both the event and broader issues related to HIV/AIDS in Memphis

and Shelby County was plentiful and continued for weeks afterwards.

- **Arrange a meeting with a newspaper's editorial board**. For example, the day before the Durham forum, meetings were arranged with the editorial boards of two area newspapers. Having a state senator (the Honorable Jeanne H. Lucas) as the co-chair of the Joint Center-Durham liaison committee made it easier to request and get such meetings with the *Duke Chronicle* and the Durham *Herald-Sun*, both major newspapers in the Durham area. Senator Lucas' sponsorship of HIV/AIDS legislation in the North Carolina General Assembly attracted the local media interest both in her and in our forum. The *Herald-Sun* not only covered the event but subsequently published an op-ed by the state senator.

G. Maintain contact with the local liaison committee or planning group after each event.

- **Disseminate materials produced after the forums to forum attendees.** Each of the four forums was featured in an article in *FOCUS*, the Joint Center's monthly publication, and copies of each article were disseminated to forum attendees as soon after each event as they became available. **(See Appendix B.)** Because the Durham forum centered around a discussion of and voting on three consensus statements, tallies from the voting were mailed to attendees along with the *FOCUS* article. At the suggestion of the Joint Center-Durham liaison committee, both the vote tallies and the *FOCUS* article also were mailed to every black legislator in the state of North Carolina. The four *FOCUS* articles have since been packaged as a set of reprints and have been distributed at other conferences and to interested parties.

- **Hold follow-up meetings with local liaison committee or planning group members.** The Joint Center returned to both Detroit (March 12, 1998) and Memphis (February 27, 1998) to meet with members of the local liaison committees at these two sites. The purpose of these meetings was to assess changes in the HIV/AIDS environments in these places since the forums had been held (roughly two years earlier) and to consider future possible initiatives. Going back to these two places made it possible to meet not only with members of the local liaison committees but also with others who had attended the forums but had not served on these committees.

HIV/AIDS in African-American Youth in North Carolina: The Role of Leadership

Durham, NC
Friday, October 3, 1997

Consensus Statement: Comprehensive, Coordinated Health Education

The attendees (community leaders, public and elected officials, activists, religious leaders, and others) at the forum sponsored by the Joint Center for Political and Economic Studies on HIV/AIDS prevention education support the need for comprehensive, coordinated health education throughout the state of North Carolina in the public school systems, as well as in alternative school systems, adjudicated youth programs, and for youth in other "out-of-the-mainstream" situations. This support is based on an understanding that all young people, including those who wait until marriage to become sexually active, have a right to and need for accurate, up-to-date information about health risks. Comprehensive, coordinated health education includes instruction about abstinence, general family health, contraception, HIV/AIDS and other sexually transmitted diseases, abortion, adoption, and hygiene.

This statement is being put forth for discussion in reaction to HB 834 (G.S. 115C-81), the "Teach Abstinence Until Marriage" bill which became law in North Carolina on July 29, 1995. This statute mandates that schools teach "Abstinence Until Marriage" programs and requires that instructional materials be made available for preview by parents before being approved by school boards for use in local systems.

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HIV/AIDS in African-American Youth in North Carolina: The Role of Leadership

Durham, NC
Friday, October 3, 1997

Consensus Statement: Needle Exchange Programs

The attendees (community leaders, public and elected officials, activists, religious leaders, and others) at the forum sponsored by the Joint Center for Political and Economic Studies on HIV/AIDS prevention education support the need for needle exchange programs to be established throughout the state of North Carolina. Needle exchange programs are "harm reduction" public health interventions designed to reduce the spread of disease by providing injecting drug users an opportunity to exchange used, blood-contaminated needles/syringes for clean unused ones. This support is based on (a) an understanding that as part of comprehensive HIV/AIDS prevention and outreach, needle exchange programs have, through scientific evidence-based research data from other states, helped to reduce needle-sharing and the spread of HIV/AIDS, Hepatitis B, Hepatitis C, and other blood-borne diseases among intravenous drug users; and (b) further, an understanding that the support of needle exchange programs does not indicate an acceptance or endorsement of drug use.

This statement is being put forth for discussion in relation to HB 576 and SB 690 that would enable the establishment of four pilot needle exchange programs. These bills were introduced in the North Carolina Legislature this year without resolution.

HIV/AIDS in African-American Youth in North Carolina: The Role of Leadership

Durham, NC
Friday, October 3, 1997

Consensus Statement: HIV/AIDS Prevention Funds

The attendees (community leaders, public and elected officials, activists, religious leaders, and others) at the forum sponsored by the Joint Center for Political and Economic Studies on HIV/AIDS prevention education support the need for one million dollars to be appropriated by the North Carolina Legislature for community-based prevention efforts to combat the HIV/AIDS epidemic. This support is based on an understanding that (a) children, women, and men of all ages and races are struggling with a costly and debilitating disease that robs us and our families of normal lives, and, finally, of life itself; and (b) this 100% preventable disease continues to rob the state of North Carolina of the potential contributions of affected individuals. Further, this support is based on an understanding that all young people and citizens of North Carolina need access to HIV/AIDS prevention and treatment programs.

This statement is being put forth for discussion in relation to HB 551 and SB 634 ("AIDS Prevention Funds"), bills pending in the North Carolina House and Senate Appropriations committees, respectively. These bills are eligible for action during the 1998 session of the North Carolina General Assembly, which will convene on May 11, 1998.

Because we were unable to return to all four sites to hold follow-up meetings, an assessment meeting for the project was convened in Washington, DC (February 19, 1999) to which representatives of all the sites were invited. The seven participants at the DC meeting included at least one person from each site. The synergy and cross-learning that took place were palpable, and the Joint Center received valuable feedback about this project and future efforts we might undertake. **(See Appendix B.)**

- **Participate in other conferences/forums related to HIV/AIDS at the sites where you are working.** If opportunities arise to participate in other HIV/AIDS conferences forums at the sites where you are working, take advantage of them. Participating in such events before the forum you are planning can allow you to advertise your event. Doing so after the forum you are hosting can allow you to sustain or reinforce your prevention education message. One example of the latter occurred when a Joint Center staff member made a presentation entitled "The Role of Black Leader-

ship as Advocates for HIV Prevention Education" in a workshop at the Western Regional Conference for HIV Educators, Administrators, Researchers, Youth, Community, and Church Leaders held in Oakland, CA, November 14-16, 1996. Although this conference (entitled *AIDS Is No Laughing Matter: The African American Community Faces the Challenge of HIV/AIDS*) took place more than a year after the Joint Center's HIV/AIDS prevention education forum (June 29, 1995), persons who both knew of the earlier event and were involved with planning the later event requested the participation of Joint Center staff.

Although the framework for organizing each forum differed somewhat, each was orchestrated using the steps outlined in the preceding section. In addition, in all the forum planning the same two crosscutting issues arose — how to organize a forum long-distance and as an outsider entity, and how to evaluate the forum's impact.

Outsider Entity

As noted earlier, the Joint Center for Political and Economic Studies is a Washington, DC-based organization without local chapters or affiliates. In undertaking the HIV/AIDS education outreach to black leaders in places other than Washington, DC, it was functioning as an outsider entity. This relationship has advantages and disadvantages. A key advantage is the ability to bring together groups that might not otherwise know about or work with each other. If the outsider organization approaches its reconnaissance without preconceived notions about the groups and individuals being contacted and thus conveys the sense that all groups and individuals are equally important to the success of the event being planned, then being an outsider can reap benefits in communitywide attendance at and support for the forum. In spite of the best efforts of an outsider entity to convey this message, however, groups sometimes will decide not to attend or participate if a rival also attends. The approach of openness and equal treatment works often enough, though, that outsider status can remain an advantage.

The disadvantages to being an outsider entity include the logistical difficulty of organizing an event long-distance and the fact that one always confronts ongoing political/social intrigues that must be sorted out in order to establish a core of reliable local contacts with whom one can work and plan a successful event. Logistical issues may include such things as financial negotiations for meeting space, catering, and the like. Being able to make a site visit when logistics need to be arranged can help, but may not always be possible. The use of facsimile machines and overnight delivery services also can help. Most helpful of all, however, is having a staff person at the outsider organization dedicated to overseeing the logistical arrangements.

Entering into the HIV/AIDS arenas of localities other than the one in which an organization is based is fraught with potential problems. Distinguishing between key players and the individuals and organizations who might seek to use the proposed forum to achieve some other unrelated goals can be tricky. Working through a local health department or local foundation can help with this assessment process, if these entities are considered user-friendly by most people in the locality. Without such a base around which to coalesce other groups, the outsider organization must use other means to find out which are the groups and the people most likely to contribute to its effort. As noted earlier in this report, the frequency with which the names of given individuals and organizations are mentioned and the context within which they are mentioned during the reconnaissance phase of planning can be very instructive toward this end.

Avoiding the perception that one's organization is a source of ready cash to support other worthwhile local initiatives is another challenge outsider organizations often confront. Stating the extent of permissible expenditures under whatever funding auspices the outsider entity is operating clearly, repeatedly, and early in the process can be helpful in this regard. Making known up front to local parties the extent of financial contributions associated with a forum also can help winnow the list of people who want to work with you to plan it. Persons interested only in the financial payout may distance themselves after learning these limits. However, knowing who you can rely upon earlier rather than later in the planning process also is a clear advantage.

Assessing Impact

Evaluating an HIV/AIDS prevention education forum that targets black leaders is not straightforward, primarily because it is difficult to define and measure the forum outcome. An informational forum to enhance awareness about issues related to HIV/AIDS instruction in local schools and to stimulate interest in or advocacy on behalf of this instruction cannot be expected to have a measurable impact on the incidence or prevalence of HIV infection and AIDS in a given community. Even if one of these forums were to have such an impact — by inspiring a parent who attended it to talk with his/her teenager so compellingly as to eliminate this youth's risk behavior entirely — it would be hard to determine that this had happened and that it had happened as a result of the forum.

The Joint Center looked at several measures to evaluate the forums. The simplest, but also the least informative, is the number of attendees. The Oakland forum attracted nearly 50 black public officials and community leaders, while the Detroit forum and the Memphis forum each had more than 70 participants, and the Durham forum had an audience of 180. Because attendance increased with the passage of time and the hosting of forums during this project, one could surmise either that our reconnaissance and organizational skills were improving or that HIV/AIDS had become a more socially accepted issue. Both may be true, and we are unable to determine which is the stronger trend. We also are unable to say whether forum attendance, even if it were the result of either of these factors, would represent an appropriate outcome measure for the forums.

Another measure used to assess the impact of the forums was to monitor media interest in and reporting about the forums. Since this also increased over time with each forum hosted, one could attribute this to similar factors as may underlie the increase in attendance. Either our skills at media outreach are improving, or HIV/AIDS has become a more socially accepted and newsworthy topic for the media. Both certainly could be true.

Yet another method used to assess forum impact was to distribute evaluation forms and compile the findings reported therein. **(See Appendix C.)** When evaluation forms are not completed by every attendee, however, the findings from the completed and returned forms are likely to be biased.* Even though our return rate for evaluation forms was less than 100 percent, these forms provide some information. For instance, across sites, a majority of those who completed the forms considered the information presented at the forum to be useful. The main impact question on the form was, "What next steps do you think should be taken to lessen the incidence of HIV/AIDS in this locality and surrounding communities?" Among respondents at all the sites, the largest majorities noted the following "next steps" as most needing to be taken: form an action group to influence program implementation in schools; and pursue initiatives on related issues (e.g., teen pregnancy).

The final method used to assess the impact of the four forums was to host follow-up meetings. Meetings were held separately in Detroit and Memphis, and a cross-site follow-up meeting was hosted in Washington, DC. One of the purposes of these meetings was to enable Joint Center staff to get an update on the sociopolitical and other changes in the HIV/AIDS arenas in the four sites since our forums. We did not expect to be able to pinpoint changes that were directly attributable to our forums, but we wanted to get a sense of the evolution of issues within and across sites.

In general, we found that many of the forces operating at the time of our forums continued to influence African American youth. Substance abuse and other high-risk behaviors remained problems for these youth in the four places. However, other forces to counteract these behaviors also have been set into motion. In Detroit, a needle exchange program has been implemented since our forum, at which the issue was publicly aired and discussed. In Memphis, the African American Church Consortium, which held its first annual conference in conjunction with its own forum, has continued to hold its annual education and leadership conference for pastors. Some of the churches there have even volunteered to offer HIV testing on their premises. In Durham and elsewhere in North Carolina, the community-based organizations that were active participants at our event have ex-

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panded their scopes and functions, in part because that state is largely without effective HIV/AIDS prevention instruction in its schools. At the Oakland forum, community members discussed their lack of HIV-related funding relative to neighboring San Francisco, and since then Alameda County declared a crisis with respect to HIV/AIDS and is using this declaration to appeal to federal, state, and local governments and other organizations for help (financial and other) to address the epidemic there.[4]

Lessons Learned

The experiences of Joint Center staff using the steps described above to organize four HIV/AIDS prevention education forums suggest a single major conclusion: using a clearly defined vehicle, such as a local liaison committee or other planning group, to obtain input from key members among the cadre of black leaders in each place was critical to the shaping and hosting of HIV/AIDS prevention education forums that were both well received and well attended. Being able to determine what entity or individuals should constitute the local working group for an outsider organization, thus, is a major initial challenge confronted when hosting HIV/AIDS prevention education forums long-distance. Since such a working group temporarily becomes a local affiliate for the outsider entity, its composition and local standing are very important to the undertaking's success.

Two corollary conclusions also can be drawn. First, it is important to include the perspectives and viewpoints of the major local sectors impacted by HIV infection and AIDS (i.e., education, health, corrections, social services, religious community) in the dialogue at the forums. Doing this allows a broad airing of issues and expands the inclusiveness of the event. It also sets a framework for audience interaction around a number of issues, both foreseen and unforeseen. Thus, the second corollary conclusion is that allowing time for exchanges among presenters and attendees is essential to having well-rounded discussions about HIV infection and AIDS. As the next sections indicate, many germane topics, issues, and recommendations emerged from the forum discussions as the result of exchanges between presenters and attendees.

OTHER APPROACHES

This section features a brief discussion of many of the approaches to providing HIV/AIDS prevention education for youths that were aired at the four Joint Center forums. The purpose of this listing is to acknowledge that classroom instruction alone may not be effective with all youth. Some of the programs/initiatives listed are adjuncts to the HIV/AIDS prevention education curricula used in schools. However, for youth who are out-of-school, incarcerated, or in juvenile adjudication settings, classroom instruction may be neither accessible nor effective.

This listing does not include all the initiatives underway at the four sites. It also does not reflect changes that may have taken place in program sites, scope, and clientele since the dates of the various forums. The listing reflects only information provided at the forums.

- **Establish church-based youth activities, to involve young people in a setting where HIV/AIDS prevention education might be delivered.** Although many African American churches and clergy are still struggling with the issues of homosexuality and sin and how to integrate discussions about and people with HIV/AIDS into their domains, others are addressing the issues head-on. These latter churches and clergy are establishing outreach activities to engage young people and then later to provide them religious instruction and other types of guidance, including HIV/AIDS prevention education. One example is a church-based marching and drummer corps for youth (mentioned at the Detroit forum), which engages the interest and energies of youth and places them in a setting where they can receive instruction about many things, including HIV/AIDS prevention. Another example (from the Memphis forum) is an HIV/AIDS church ministry, which has as its primary mission to meet the needs (e.g., social, medical, and spiritual) of HIV-positive persons but which serves a secondary purpose of educating the congregation by involving HIV-positive persons more fully in the church.

- **Provide peer counseling within a school system.** The Joint Center's HIV/AIDS prevention education forums are not the first, nor are they likely to be the last, settings in which the merits and advantages of peer counseling are extolled. In the forums held in Oakland, CA, and in Detroit, MI — two places with an HIV/AIDS prevention education curriculum in place within their local school systems — the training and use of peer educators or counselors as an adjunct to classroom instruction was noted. In Oakland, for example, youth ages 14 to 17 receive the peer education component of the general HIV/AIDS curriculum. Those who become peer educators wear t-shirts that they designed and produced, bearing HIV prevention messages, whenever they speak before audiences.

- **Make judicious use of school-based health centers.** In Detroit, where health centers are in place in several schools, their judicious use to convey HIV/AIDS prevention education was advocated. The types of funding received by the school-based health centers and the implications of this for the type of instruction that can be provided there must be determined before HIV/AIDS prevention education can be offered. However, the location and hours of operation of these centers may provide an opportunity to reach large numbers of youth.

- **Incorporate HIV/AIDS prevention education with other programs to reduce high-risk behavior among youth.** The national teen pregnancy prevention program of Girls, Inc., as implemented in the Memphis schools was cited during that city's forum as a likely place to insert

HIV/AIDS prevention education messages. The mention of substance abuse during the forums in Detroit, Durham, and Oakland suggests another high-risk behavior whose prevention messages and programs could be shaped to include HIV/AIDS.

- **Use the arts to convey HIV/AIDS prevention messages.** At the Oakland forum, the AIDS Project of the East Bay (APEB) was noted as a successful example of a program that reaches youth interested in music, art, and drama by using this interest as an entree to provide HIV/AIDS education. Because these performance arts are no longer fully funded in many public school districts, students who are talented in them may not be as fully engaged in school as are youth with other talents. The APEB program recruits students talented in the creative arts and gives them 10 sessions of HIV/AIDS education as a prerequisite for being able to participate in a Showcase, involving a public display of creative works. In March 1995, for instance, APEB hosted a very successful Showcase, attracting an audience of over 300 students, their parents, and other adults to view student art, music, and dramatic creations, around the theme of preventing HIV/AIDS.

  Another example of the use of the arts to foster HIV/AIDS prevention education is found among the peer educators who work within the Oakland Unified School District (OUSD). The peer educators have created a "living quilt," on whose squares HIV/AIDS prevention messages are found. The quilt is displayed by the peer educators when they make presentations.

- **Integrate the HIV/AIDS prevention education message with other community activities.** For example, at the Oakland forum, the California Prevention Education Program (CAL PEP) was described as an entity that conducts outreach, research, and intervention with young women ages 15 to 34 in the East Bay area. It also organizes festivities for holidays such as Kwanzaa and Juneteenth[10] and incorporates an HIV/AIDS prevention message into these events. In addition, CAL PEP has developed Afro-centric literature about HIV/AIDS prevention, which is distributed to local businesses and residents on an ongoing basis.

ISSUES AIRED

The discussions at the Joint Center's four HIV/AIDS prevention education forums were lively and ranged from things that are working well to things that are not working at all. The discussions aired situations and circumstances related both to individuals and to institutions that need to be ameliorated to enhance the effectiveness of HIV/AIDS prevention education for African American youth. Many of these issues are noted below.

- **Failure of school systems to offer statutorily mandated family life curriculum.** Some of the youth who came with their parents to the Memphis forum, a Saturday event, lamented the lack throughout their school careers of mandated family life instruction. Others pinpointed the comfort levels or prejudices of administrators as determinants of the instruction provided at individual schools within the Memphis system. The lack of comprehensive planning, policies, and programs for health also was noted as a reason why the mandatory system-wide family life curriculum has not been implemented.

  The censoring of school instruction about HIV/AIDS and sexuality, which was noted at the Memphis forum, is a national problem. Despite national polls that show that between 80 percent and 90 percent of adults support sex education in schools, much of that instruction is about abstinence only. In a 1994 CDC survey, 78 percent of teachers reported that they taught abstinence in their sex education class, while only 56 percent discussed condom use to prevent HIV infection, and only 37 percent explained proper condom use.[11]

- **Inadequacy of messages about sexuality and HIV/AIDS prevention provided within the school system.** At the Detroit forum, several attendees questioned quality of instruction in the system's mandated curriculum. For example, some felt that education still is needed — but not being provided — to dispel the belief that only people who are gay or lesbian are susceptible to HIV/AIDS. Others at this forum cast the issue of inadequacy of messages about HIV/AIDS and sexuality differently. Messages targeted to mainstream America, they noted, are likely to be inadequate for African Americans because of behavioral and cultural differences. School systems in which African American youth are the dominant population have an obligation to provide messages tailored to this behavioral and cultural subpopulation. In addition, African Americans have an obligation to demand that culturally appropriate messages be provided.

  Yet others felt that more attention should be given to answering a question that youths commonly ask — "Where does AIDS come from?" Answering this question effectively for African American youth is key to changing beliefs such as were found among the 18 percent of African Americans in a recent survey who believe that AIDS is an engineered virus, and among the 10 percent of African Americans who believe that AIDS is part of a genocidal plot to kill black people.[12]

  At the Memphis forum, the need for basic education about HIV/AIDS was framed in the context of eliminating the fear of people who have HIV/AIDS that stems from ignorance about modes of transmission. The abandonment of HIV-positive teens by their families, including many teens who were pregnant, also was noted as a possible result of inadequate education about the causes, nature, and treatment of HIV/AIDS.

  At the Oakland forum, youths' mistrust of both messages and messengers regarding HIV/AIDS was noted. This lack of trust renders messages

that are factually correct "inadequate" to protect youth from behavior that might place them at risk.

- **Inadequate funding to train teachers to convey HIV/AIDS prevention education messages.** An impediment to effective HIV/AIDS prevention education noted at several forums was inadequately trained teachers. Forum attendees noted that careful consideration must be given to which teachers of which genders and which subject areas can best integrate HIV/AIDS prevention messages into their course topics in a manner that will be well received. For example, in the OUSD the mandated HIV/AIDS prevention education is incorporated into the curricula of two required courses — 8th grade science and 10th grade world cultures. School nurses within the school district also make themselves available to cover sensitive topics within class lessons, upon request from the teachers. Although many in Oakland find this approach to be effective, the inadequacy of funding to train teachers or others to convey these prevention messages remains an issue there.

  In addition, African American youths more often than white youths attend underfunded inner city schools; some of these systems are under receivership and many of these systems are under fire to improve basic reading and math competencies. In a competition for the use of the limited funds available to these systems, HIV/AIDS prevention education often receives a lower priority than many other things and, thus, may not be implemented.

- **Inadequacy of education about HIV/AIDS prevention for youth and young adults who are incarcerated.** The incidence of HIV infection and AIDS among incarcerated persons has been noted to be six times the rates of persons not in the correctional system.[13] During the Memphis forum, in particular, HIV/AIDS education, testing, and treatment within the city jail were all branded as flawed, where "John Doe" had become infected with HIV while incarcerated. Because youth and young adults in prison or in juvenile detention are not in school, this issue highlights the need to provide prevention education messages to all youth, regardless of the venue.

- **Failure of churches to openly address issues related to HIV/AIDS.** A participant at the Memphis forum labeled the failure of churches to deal with HIV/AIDS as part of the broader failure of churches to openly address issues related to death. Several participants at the Oakland forum pinpointed homophobia and the definition of homosexuality as sin as problems that play a larger role in keeping African American churches from participating in the struggle against HIV/AIDS. The need to train and educate clergy about HIV/AIDS was noted, as was the need for churches to provide a broad array of services (social, health, and educational) to African American youth.

RECOMMENDATIONS

The recommendations presented below reflect the discussion at the four Joint Center forums as well as at the subsequent assessment meetings in Detroit, MI, Memphis, TN, and Washington, DC. They address things that could be done — in addition to hosting forums similar to the ones organized by the Joint Center — to enhance the provision of effective HIV/AIDS prevention education for African American youths. These recommendations are not meant to be all-inclusive, but to highlight the sentiments expressed to us during the five-year project.

- **Develop multifaceted prevention programs to address the health needs of African American youths.** In 1997, AIDS was the leading cause of death among African Americans between the ages of 25 and 44, with more than 60 percent of these deaths related to injecting-drug use.[14] Because teen pregnancy, substance abuse, and HIV/AIDS often come as a package, addressing these issues simultaneously could create a synergy that would be more effective than addressing each issue in isolation.[15] In localities with school-based health programs or centers, interventions that take place there could be used to change youths' high-risk behaviors. In localities without a school-based health-center infrastructure, the challenge is to gain access to students/youths without using a formal structure. In one example used in communities without a sex education or family life curriculum in place, health educators make HIV/AIDS educational presentations before classrooms whose teachers are willing to allow this and who have signed permission slips from parents to authorize the presentations to their offspring. Another example integrates HIV/AIDS prevention education and other interventions with ongoing community activities to foster greater youth involvement and to provide valuable prevention messages about potential health problems among African American youth.

- **Involve all individuals and institutions in a community in the prevention of HIV/AIDS.** Churches, other community institutions, and all their individual members need to be involved in educating African American youth to avoid high-risk behavior from which they could get HIV infection and AIDS. In particular, community institutions should make communities "safe for youth to be different in." Whether the difference relates to sexual orientation or to enjoying scholarly pursuits, community institutions should create an environment in which youth can feel that they do not have to engage in high-risk behaviors in order to fit in. In other words, community institutions must confront the challenge of creating alternatives to the cultures of sex, violence, and drugs that are central to the spread of HIV/AIDS. Cross-fertilization among community institutions — e.g., a pastor serving on the board of directors of a community-based organization that provides HIV/AIDS prevention education and other services — is one way to bolster this process.

  Although not always viewed as a community institution, the criminal justice or corrections systems need to work with other institutions to help prevent HIV/AIDS among youth. Prevention education, access to condoms, testing, and treatment throughout the nation's correctional systems would help make inroads against the epidemic.

- **Provide HIV/AIDS prevention education and training for all segments of the population as a way to most effectively reach youths.** A key concern at the Joint Center forums was the persistent ignorance about the nature and transmis-

sion of HIV infection. One way to meet this pervasive need for education among youths is to provide it to adults as well. It is clear that the behavior and attitudes of youths can be modified by modifying the behavior and attitudes of the adults with whom youths live. Including parents and guardians as recipients of HIV/AIDS education and prevention messages may create a familial synergy that can "immunize" youth against high-risk behaviors and one of the consequences, HIV infection. In addition, providing prevention messages to youth that build upon their strengths, rather than focus on their deficits — something both parents and teachers can do — may result in the most lasting behavior modification and guaranteed prevention of HIV/AIDS.

Representatives of the religious community attended all the Joint Center forums, and the clergy was specifically mentioned as a critical population to engage in the process of educating African American youths and adults about preventing HIV/AIDS. Training and education targeted to clerics could do much to change the environment in African American communities in which HIV/AIDS prevention messages are being promulgated. Rev. James Michael Curenton, an African American outreach coordinator for the AIDS Interfaith Network in Detroit, noted that many community churches and their clergy have shied away from dealing with the subject of HIV/AIDS or have taken the position that HIV/AIDS is a punishment from God. However, now that the disease affects all sectors of the African American community, it is becoming more obvious that this posture needs to change.[18] Education could play a key role in this.

- **Provide adequate funding for program evaluations.** One of the barriers to HIV/AIDS prevention education is the lack of materials to implement programs that have proven effective in encouraging the necessary behavior changes. Underlying this lack of materials is a lack of funding to evaluate prevention interventions and determine which ones work and which do not, as well as how they work and with which populations they work best. Published evaluations and assessments are much more common for programs that work than for programs that do not, in spite of the need to have information about both readily accessible to those who may want to carry them out. Community-based organizations that want to prevent HIV/AIDS do not want to "reinvent the wheel" with every initiative they undertake. They also would like to be able to avoid and learn from the mistakes of others. Funding program evaluations and disseminating their findings widely could help address this need.

NOTES

1. Office of National AIDS Policy, *Youth and HIV/AIDS: An American Agenda*, March 1996, p. i.

2. http://www.census.gov/population/www/estimates/nat_90s_2.html

3. Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report*, 1998; 10 (No. 1): 15.

4. Summary of "HIV Infection in Disadvantaged Out-of-School Youth: Prevalence for US Job Corps Entrants, 1990 Through 1996," *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, Vol. 19, No. 1, in CDC NCHSTP Daily News Update, Friday, August 28, 1998.

5. See J.A. Kelly, "Community-Level Interventions Are Needed to Prevent New HIV Infections," *American Journal of Public Health*, Vol. 89, No. 3, March 1999, pp. 299-301; and J.A. Kelly, J.S. St. Lawrence, Y.E. Diaz, et al., "HIV Risk Behavior Reduction Following Intervention with Key Opinion Leaders of Population: An Experimental Analysis," *American Journal of Public Health*, Vol. 81, No. 2, February 1991, pp. 168-171.

6. The mission of the Joint Center for Political and Economic Studies is to illuminate the major national public policy debates through research, analysis, and information dissemination intended to improve the socioeconomic status of African Americans, to expand their effective participation in the political and public policy arenas of the nation, and to promote communications and relationships across racial and ethnic lines.

7. The Joint Center's 1993 edition of *Black Elected Officials: A National Roster* was the last printed book version of the BEO roster. Due to changes in information technology, the Joint Center no longer publishes the roster as a bound book. Statistical reports about BEOs will be published on a regular basis, and information also will be available at no cost through the Joint Center's website (www.jointcenter.org). Detailed information about black elected officials, including their names, addresses, and levels of office, is available for purchase as label and list printouts. For more information, contact the Joint Center for Political and Economic Studies' Office of Communications and Marketing.

8. Persons who complete and return evaluation forms can generally be assumed to be more engaged with an issue than people who do not.

9. Steve Sternberg, "Nationline: California County Appeals for Help in AIDS Fight," *USA Today* (November 5, 1998), p. 20A, in CDC HIV/STD/TB Prevention News Update, Thursday, November 5, 1998, pp. 2-3.

10. Although the Emancipation Proclamation was signed January 1, 1863, the slaves in Texas did not learn of their emancipation until June 19, 1863. Juneteenth is celebrated on June 19 to commemorate this.

11. "Sex Education Gets Censored in Some U.S. Schools," *Fox News Online* (August 24, 1998) in CDC HIV/STD/TB Prevention News Update, Tuesday, August 25, 1998, p. 4.

12. David France, "Challenging the Conventional Stance on AIDS," *New York Times* (December 22, 1998), p. D6 in CDC HIV/STD/TB Prevention News Update, Tuesday, December 22, 1998, p. 2.

13. Darryl Fears, "AIDS Among Black Women Seen as a Growing Problem," *Los Angeles Times — Washington Edition* (July 24, 1998), p. A1 in CDC NCHSTP Daily News Update, Friday, July 24, 1998, p. 3.

14. Dawn Day, *Health Emergency 1999: The Spread of Drug-Related AIDS And Other Deadly Diseases Among African Americans and Latinos*. Princeton, NJ: The Dogwood Center, p. 1.

15. David S. Metzger, Helen Navaline, and George E. Woody, "Drug Abuse Treatment as AIDS Prevention," *Public Health* (June 1998), Vol. 113, Supplement 1, p. 97, as summarized in CDC NCHSTP Daily News Update, Wednesday, August 26, 1998, p. 2.

16. Jeff Gerritt, "Breaking the AIDS Silence," *Detroit Free Press Online* (September 29, 1998) in CDC HIV/STD/TB Prevention News Update, Tuesday, September 29, 1998, p. 3.

APPENDIX A

HIV/AIDS and African American Youth: Factsheets

- Detroit
- Durham, Orange, and Wake Counties in North Carolina
- Memphis
- North Carolina
- Oakland and the East Bay
- United States

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HIV/AIDS AFRICAN-AMERICAN YOUTH

DETROIT MICHIGAN

- In 1994 and through June 1995, 85 percent of reported cases of AIDS in the United States were among residents of large metropolitan areas with 500,000 or more population.[1]

- Between July 1994 and June 1995, the state of Michigan reported 1,071 AIDS cases, which translates into an annual rate of 11.3 cases for every 100,000 population.[1]

- As of October 1, 1995, 36% of all AIDS cases in Michigan were related to injection drug use. In addition, among African-American females with AIDS, sixty-five percent give a history of injecting drug use, and thirteen percent had male partners who were injecting drug users.

- In Detroit between July 1994 and June 1995, a total of 778 AIDS cases were reported for an annual rate of 18.1 per 100,000 population. The 1994-95 figure represents an increase from 1993-94 when 659 cases were reported at an annual rate of 15.3 per 100,000.[1]

- Between April 1992 and June 30, 1995, thirty-seven (37) cases of HIV infection -- nearly 2 percent of the total of 2,251 cases reported in the city of Detroit -- were reported among youth 14-19 years of age. Over the same time period, 519 cases (nearly a quarter of all cases) were reported among young adults ages 20-29.[2] These figures suggest the importance of providing effective HIV/AIDS instruction to modify the behavior of youth.

- Because a large majority of both the pediatric cases of HIV infection (among persons under 13 years of age) and the adult cases of HIV infection (among persons 13 and older) occur among blacks (92 percent and 89 percent, respectively),[2] the proportion of Detroit adolescents with HIV infection who are black also is likely to be large. (April 1992 through June 30, 1995)

- From 1981 through the end of June 1995, twelve (12) cases of AIDS -- less than 0.5 percent of the 3,068 AIDS cases reported during that period -- were reported among youth ages 14-19 in the city of Detroit. As with HIV infection, reported AIDS incidence increases markedly between ages 14-19 and 20-29. More than 500 cases, or nearly 17 percent of all the AIDS cases reported in that time period, were reported among 20-29-year-olds.[2]

- Because the majority of both pediatric cases (persons under 13 years of age) and of adult cases (persons 13 years of age and older) of AIDS are reported among black Americans (97 percent and 86 percent, respectively),[2] the proportion of black adolescents among all adolescents with AIDS also is likely to be high in Detroit. (1981 through June 30, 1995)

Compiled by: Wilhelmina A. Leigh
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SOURCES

1. Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report, 1995;7(no.1).

2. Office of Epidemiology & Communicable Disease, Detroit Health Department, July 24, 1995.

This Fact Sheet has been reviewed and approved by a national panel for use with general audiences.

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JOINT CENTER FACT SHEET

HIV Infection and AIDS Among Youth

Durham, Orange, and Wake Counties in North Carolina

AIDS

- Between January 1981 and June 30, 1997, among the three counties, Wake County had the largest number of cases of AIDS (726 cases)—nearly 10 percent of the 7,576 cases reported in the state of North Carolina. Durham County was next with 581 cases (8 percent), and Orange County reported the smallest number—91 cases (1 percent of the state total). Although Wake County reported nearly 10 percent of all AIDS cases in the state, only 7 percent of the population of North Carolina lives in Wake County. Similarly, Durham County reported a larger share of all the AIDS cases in the state (8 percent) than its proportion of the state population (nearly 3 percent). AIDS cases and population in Orange County were comparable shares of the state totals.
- During the same 1981–1997 period, nearly three-fourths (73 percent) of reported AIDS cases among adults and adolescents 13 years of age and older in Durham County were among African Americans, as were nearly three-fifths (59 percent) of the cases among adults/adolescents in Wake County. In Orange County, the majority of adult/adolescent cases (57 percent) were among whites, with African Americans accounting for 41 percent.
- During the 1981–1997 period, in Durham County, African Americans accounted for 69 percent of the AIDS cases among males and 92 percent of the cases among females. In Wake County, they accounted for 54 percent of the cases among males and 89 percent of the cases among females. In Orange County, although African Americans made up 75 percent of the cases among women, they were not the majority of males (37 percent) affected there.
- The major causes of AIDS among African Americans in Wake and Orange counties during the 1981–1997 period were injecting drug use for females and men having sex with men for males. In Durham County, injecting drug use was the major cause among black males (41 percent), followed by men having sex with men (28 percent). For females in Durham County, heterosexual contact and injecting drug use accounted for equal shares (41 percent) of the cases of AIDS.
- In the first half of 1997, Wake and Durham counties accounted for a sizable share of the 425 reported AIDS cases among adults/adolescents in the state as a whole. Wake County reported 45 AIDS cases (11 percent of all cases in the state), while Durham County reported 34 cases (8 percent). Orange County reported only two cases, one-half of 1 percent of all AIDS cases in North Carolina. African Americans accounted for large majorities of the AIDS cases reported in both Durham County (88 percent) and Wake County (84 percent). One of the two cases in Orange County was reported by an African American adult.
- Youth ages 13 to 19 accounted for at most 1 percent of AIDS cases in the three counties between January 1981 and June 30, 1997. However, 28 percent of AIDS cases in Orange County and nearly a fifth of cases in both Durham and Wake counties (19 percent) were among persons ages 20 to 29, many of whom contracted HIV infection during their teen years.

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- Youth ages 13 to 19 accounted for none of the cases of AIDS in the three counties during the first half of 1997. Although Orange County also reported no cases among young adults ages 20 to 29, in Durham County, seven cases (21 percent) were diagnosed among persons in that age group, as were six cases in Wake County (13 percent).

HIV Infection

- As with cases of AIDS, the reported incidence of HIV infection in Wake County—651 adult/adolescent cases, and 9 percent of all cases in the state—between February 1990 and June 30, 1997, was greater than in either Durham County (430 cases and 6 percent of all cases in the state) or Orange County (81 cases and 1 percent of all cases in the state).
- During the same 1990–1997 period, African Americans accounted for the majority of cases of HIV infection in the three counties, ranging from 65 percent in Orange County to 77 percent in Wake County to 89 percent in Durham County. In each county, the majority of these cases were reported by adult/adolescent males.
- Youth ages 13 to 19 accounted for 2 percent of all cases of HIV infection in Durham County and Wake County, and 5 percent of all cases in Orange County, during the 1990–1997 period. In the first half of 1997, the number of cases remained small. The one case reported in Wake County among 13- to 19-year-olds was 2 percent of all cases, while the one case in Orange County represented 25 percent of all cases reported there; in Durham County, for this age group no cases were reported.
- Men having sex with men or injecting drug use was the dominant cause of HIV infection among adults/adolescents in the three counties during the 1990–1997 period.
- Of the 524 cases of HIV infection reported among adults/adolescents in North Carolina during the first half of 1997, Wake County also reported the largest share (8 percent), followed by Durham County (4 percent), and then Orange County (0.8 percent).
- African Americans accounted for between 50 percent and 100 percent of the cases of HIV infection reported during the first half of 1997, ranging from 50 percent in Orange County to 78 percent in Wake County to 100 percent in Durham County.
- Although the exposure category was not reported for a sizable share of the cases of HIV infection reported in the three counties during the first half of 1997, injecting drug use accounted for the largest shares of all cases among both females (40 percent) and males (29 percent) in Durham County. Men having sex with men accounted for the greatest proportion of all cases among males in Wake County (41 percent) and Orange County (67 percent), while heterosexual contact was a leading cause (25 percent) of HIV infection for females in Wake County. The exposure category was not reported for the one case of HIV infection in an adult/adolescent female in Orange County.

Prepared by Wilhelmina A. Leigh, based on data provided by the North Carolina Department of Environment, Health & Natural Resources, Office of Epidemiology & Special Studies, HIV/STD Control Section, October 1997.

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MEMPHIS, TENNESSEE

- An estimated 11,000 to 14,000 Tennesseans were HIV positive, and another 2,300 persons throughout the state were living with AIDS, by the end of 1994.[1]
- HIV infection is a health problem for people in both the urban and rural areas of Tennessee, with 94 of the 95 counties in the state having reported one or more persons who are HIV positive (from January 1, 1992 through April 30, 1995).[2]
- AIDS was the fourth leading cause of death for persons ages 25 to 44 in Tennessee in 1993.[2]
- African Americans reported 35 percent of all AIDS cases in the state -- a cumulative total of 1,759 cases out of the 5,042 cases reported from 1982 through June 30, 1995. African Americans also account for 61 percent of the cases of HIV infection within the state.[3]
- Twenty-five (25) percent of all persons with AIDS in Tennessee are 20-29 years old, many of whom were infected during their teen years.[3]
- Teens represent over 4 percent of the reported cases of HIV infection in Tennessee, and the majority of these teens (76 percent) are African American. Persons ages 13 to 25 represent 23 percent of all reported cases of HIV infection.[3]
- Among 13-to-19-year olds in the state, thirty-six (36) cases of AIDS (0.74 percent of all cases) and 149 cases of HIV infection (3 percent of all cases) were reported (from 1982 through April 30, 1994).[2]
- The proportion of HIV-infected African Americans between the ages of 13 and 29 is greater than the proportion of African Americans with AIDS in the same age group. This suggests a continued spread of the disease among adolescents and young adults.[4]
- Of the 1,309 African Americans with AIDS in Tennessee as of June 30, 1994, nearly a third (31 percent or 400 cases) were 20-29 years of age at the time of diagnosis, indicating the possibility of HIV infection during adolescence. An additional 14 cases (1 percent) were 13 to 19 years of age at diagnosis. Of the 1,346 African Americans with HIV infection, almost half were 13 to 29 years of age.[4]
- Of the 1,737 adolescent and adult African Americans with AIDS, 35 percent (623 cases) reported injection drug use or having sex with injection drug users as the responsible risk behavior.[3]

MEMPHIS/SHELBY COUNTY

- The highest incidence of AIDS is found in Tennessee's four largest urban areas -- Memphis/Shelby County; Nashville/Davidson County; Chattanooga/Hamilton County; and Knoxville/Knox County. Seventy-nine percent (1,381) of all African Americans reported with AIDS in Tennessee resided in one of these four areas at the time of diagnosis, with the majority (48 percent) residing in Memphis/Shelby County.[3]

- The incidence of AIDS in Memphis/Shelby County in 1994 was 28 per 100,000, more than double the state rate of 13 persons per 100,000. Memphis/Shelby County also reported the greatest number (382) and largest share (40 percent) of cases of HIV infection in the state in 1994.[2]

- Total AIDS cases in Memphis/Shelby County were 1,569, along with 1,965 cases of HIV infection (April 30, 1995).[5]

- Although the numbers of reported AIDS cases among persons ages 13 to 19 in Memphis/Shelby County have been 2 in 1992, 3 in 1993, and 3 in 1994, the numbers of cases of HIV infection reported among this same age cohort were much greater -- 17 in 1992; 24 in 1993; and 25 in 1994. This pattern suggests an increased incidence of AIDS among teens and young adults in the future.[2]

- While only 1 percent (13 cases) of the AIDS cases reported in Memphis/Shelby County (cumulative through 9/30/95) were among youth ages 13 to 19, over a fourth (27 percent or 422 cases) were among persons ages 20-29. Similarly, while only 5 percent of the cases of HIV infection reported in Memphis/Shelby County were among youth ages 13 to 19, nearly two-fifths (38 percent) were reported among the 20-to-29-year olds.[5]

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NOTES:

1. ***Tennessee Department of Health, The Scope of the HIV Epidemic in Tennessee: Fact Sheet Update Through 1994.***

2. ***1996 Tennessee HIV Prevention Plan.***

3. ***Epidemiological Report, 1996 Tennessee HIV Prevention Plan.***

4. ***Tennessee Department of Health, The Impact of HIV and AIDS on African-American Tennesseans, Update Through June 30, 1994.***

5. ***Memphis-Shelby County AIDS Surveillance Report and Memphis-Shelby County HIV Surveillance Report, both cumulative through September 30, 1995.***

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HIV Infection and AIDS Among Youth

North Carolina

Adults/Adolescents: AIDS

- Although only 22 percent of the population of North Carolina, African Americans accounted for 63 percent of the 7,576 cases of AIDS reported in the state among adults and adolescents age 13 and older between January 1981 and June 30, 1997. During the first half of 1997, African Americans accounted for 73 percent of all reported cases of AIDS among adults/adolescents in North Carolina.
- The majority of adult/adolescent cases of AIDS in North Carolina during the 1981–1997 period (83 percent) were among males.
- The majority of cases of AIDS in North Carolina among both sexes were reported among African Americans. Blacks accounted for 84 percent of all cases among females and 59 percent of all cases among males during the 1981–1997 period.
- Heterosexual contact was the reported cause for 40 percent (531 cases) of the cases of AIDS among females in the state during the 1981–1997 period, while injecting drug use caused over a third (34 percent) of the cases. In the first half of 1997, over a third of AIDS cases among adult/adolescent females were due to injecting drug use, with nearly as many cases (29 percent for each) due to heterosexual contact and with the cause not reported.
- Men having sex with men was the reported cause for nearly half (47 percent) of all cases of AIDS among male adults/adolescents during the 1981–1997 period. This source of infection remained the major cause of AIDS cases among adult/adolescent males in the first half of 1997 (32 percent); a fourth of all cases among males (25 percent) were attributed to injecting drug use, while for 28 percent of the cases, no cause was reported.

Adults/Adolescents: HIV Infection

- During the period February 1990 to June 30, 1997, African Americans—at 76 percent—accounted for an even larger share of the 7,366 cases of HIV infection reported among adults/adolescents in North Carolina, than they did of the cases of AIDS in the state. African Americans accounted for 76 percent of all cases of HIV infection reported in the state during the first half of 1997, as well.
- Both African American males and African American females also accounted for majorities of the cases of HIV infection during this 1990–1997 period, reporting a larger share of all cases among females (81 percent) than among males (74 percent).
- The cause of HIV infection among adult/adolescent females during this 1990–1997 period was not reported for nearly half of the cases (46 percent). Heterosexual contact was credited for nearly a third (32 percent), while injecting drug use was responsible for about a fifth (19 percent). In the first half of 1997, no cause was reported for over half of all cases of HIV infection among women (53 percent), while 34 percent reported infection from heterosexual contact, and 11 percent indicated that injecting drug use was the cause.

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- Although men having sex with men accounted for 31 percent of all cases of HIV infection among adult/adolescent males between February 1990 and June 30, 1997, in an even larger proportion of cases (35 percent), the cause of infection was not reported. This pattern continued during the first half of 1997, when the cause was not reported for 36 percent of the cases among men; nearly a third (32 percent) of the cases reported during that period were due to men having sex with men, and 15 percent were due to injecting drug use.

Young Adults/Teens: AIDS

- Only 1 percent (58 cases) of all AIDS cases reported among adults/adolescents in North Carolina between January 1981 and June 30, 1997, were among teens (ages 13 to 19), while a fifth (20 percent) were reported among persons ages 20 to 29. Only one case of AIDS was reported among teens throughout the state during the first half of 1997.
- Among pre-teens and teens (youth ages 10 to 19) as well as among young adults ages 20 to 29, during this 1981–1997 period black males and black females accounted for large shares of the reported AIDS cases. African Americans accounted for 49 percent of all AIDS cases among male youth ages 10 to 19 and 56 percent of all cases among males ages 20 to 29. Blacks accounted for a very large share of AIDS cases among female youth ages 10 to 19—77 percent—and also reported 39 percent of all cases of AIDS among females ages 20 to 29.

Young Adults/Teens: HIV Infection

- Teens (ages 13 to 19) of all races accounted for 3 percent and adults ages 20 to 29 accounted for 34 percent of all cases of HIV infection in the state of North Carolina between February 1990 and June 30, 1997.
- During the first half of 1997, the proportion of teens of all races, as a share of all adults/adolescents who reported cases of HIV infection, rose to 4 percent. At the same time, the proportion of young adults ages 20 to 29 reporting HIV infection was slightly lower (30 percent) than the share during the 1990–1997 period (of 34 percent).
- African Americans accounted for the majority of cases of HIV infection among males and females ages 10 to 19 and 20 to 29. Among the 10-to-19 age group, blacks reported 73 percent of the cases among males and 81 percent of cases among females. In addition, among the young adult group (ages 20 to 29), blacks made up 68 percent of reported cases among young adult males and 80 percent of the cases among young adult females.

Prepared by Wilhelmina A. Leigh, based on data provided by the North Carolina Department of Environment, Health & Natural Resources, Office of Epidemiology & Special Studies, HIV/STD Control Section, October 1997.

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HIV/AIDS AFRICAN-AMERICAN YOUTH

OAKLAND and the EAST BAY

- The majority of cases (58 percent) of **AIDS opportunistic illnesses** reported in 1994, as in previous years, were among residents of five states -- NY, CA, FL, TX, and NJ.[1]

- In both 1993 and 1994, 84 percent of reported cases were among residents of large metropolitan areas with 500,000 or more population.

- A study of HIV incidence among street-recruited intravenous drug users in Northern **California revealed higher** rates in East Palo Alto, Richmond, and West Oakland than among the comparable group in San **Francisco. This finding** was cited as evidence that when substantial HIV/AIDS prevention programs are focused on major **cities (such as** San Francisco), neighboring communities have not benefited from the efforts, in part because these communities lack the financial and human resources to implement their own programs.[2]

- In 1994, the state of California reported 12,136 **AIDS** cases, which translates **into an annual rate of 38.6 cases for** every 100,000 population.[1]

- In Oakland in 1994, a total of 977 **AIDS cases** were reported for an **annual** rate of **45 per 100,000 population. The** 1994 figure represents a decline from 1993, when 1,293 **cases** were reported **at an** annual **rate of 60 per** 100,000.[1]

- The incidence of AIDS in the East Bay, based on cases reported **cumulatively** between **1980 and 1994, is** greatest **in the** following five places -- Oakland, Emeryville, Richmond, San Pablo, **and** Berkeley.[3]

- As of May 12, 1994, in East Bay communities, 4,863 **residents were** reported **to have received a diagnosis of** AIDS. **This** includes 3,474 residents of Alameda County (nearly 72 **percent of the** total) and **1,386 residents of** Contra Costa County.[3]

- As of May 12, 1994, although **AIDS cases** were reported among whites in **the East Bay in nearly the same proportion** that whites represent of the total population -- that is, whites reported nearly 56 **percent of the AIDS cases and were nearly** 60 percent of the East Bay population -- African Americans were overrepresented **among persons reporting AIDS. African** Americans are 14 percent of the population of the East Bay but reported **a third of all AIDS cases there.**[3]

- Of the people with AIDS in the East Bay, 14 percent were diagnosed in their twenties, **many** of **whom were** infected with HIV during their teen years. Ten **teenagers** (0.2 percent of the people in the East **Bay with AIDS) and 29** children (0.6 percent) also were diagnosed with AIDS as of May 12, 1994.[3]

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SOURCES

1. *Centers for Disease Control and Prevention (CDC). HIV/AIDS Surveillance Report, 1994;6(no.2).*
2. *J.K. Watters, R.N. Blumenthal, and A.N. Krol. HIV Seroprevalence in Injection Drug Users. Journal of the American Medical Association (JAMA), vol. 273, no. 15, (April 19, 1995): 1173.*
3. *J. Reardon. HIV/AIDS Epidemiology Profile of the EAST BAY, California. Alameda County Health Care Services Agency and Contra Costa County Health Services Department, October 1994.*

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HIV Infection and AIDS Among Youth

United States

- Between 1981 and December 1996, nearly 600,000 cases of AIDS (acquired immunodeficiency syndrome) were reported among the U.S. population. The vast majority of these 581,429 cases (99 percent) were reported among adults and adolescents 13 years of age and older, with the remaining 1 percent (7,629 cases) among children. [1]
- Males accounted for most AIDS cases (85 percent) among adults/adolescents 13 years of age and older reported through December 1996, and whites accounted for half of all cases (51 percent) among these males. Blacks accounted for a disproportionately large share (31 percent) of all AIDS cases among male adults/adolescents, when compared to their 12 percent share of the male population. [1]
- Among persons ages 13 to 19 years during the 1981–1996 period, 2,754 cases of AIDS were reported, as were 21,097 cases among persons ages 20 to 24 years. In addition to full-blown cases of AIDS, 3,194 cases of human immunodeficiency virus (HIV) infection were reported among persons ages 13 to 19 years, along with 12,272 cases among persons 20 to 24 years of age. [1]
- By some projections, blacks are expected to account for more than half of all reported cases of AIDS by the end of the year 2000. [2]

Cases and Causes

- Although punctuated with declines in selected years, the number of AIDS cases reported each year among U.S. adolescents (ages 13 to 19) has increased from 1 case in 1981 to 403 cases in 1996. HIV infection was reported among 554 youth ages 13 to 19 years in 1996, as well. [1,3]
- Because of the lengthy incubation period between infection with HIV and the onset of AIDS, many of the 2,171 cases of AIDS reported among persons ages 20 to 24 years during 1996 were likely to stem from HIV infection during the teen years. One in four new cases of HIV infection now occurs among persons under the age of 22. [1,4]
- Black adolescents accounted for large shares of the 3,194 cases of HIV infection reported through December 1996. Out of all cases of HIV infection reported among adolescents, black males accounted for 27 percent and black females for 37 percent. The 1,185 cases of HIV infection among black females more than triple the 342 cases among white female adolescents and reflect the increasing prevalence of the disease among young black females. [1]
- Similarly, black adolescent males and females accounted for a large percentage of cases of AIDS reported through December 1996. Black males reported 605 cases of AIDS and black females reported 659 cases of AIDS among persons 13 to 19 years of age. Together, they accounted for nearly half (46 percent) of all cases reported by adolescents since 1981. [1]
- More than a third (35 percent) of males ages 13 to 19 years who reported a case of AIDS in 1996, indicated that they had been infected through sex with other males; a fourth reported hemophilia or coagulation disorder as the cause of infection. [1]

This fact sheet has been reviewed and approved by a national panel for use with general audiences.

- Nearly half (46 percent) of the females ages 13 to 19 years who reported a case of AIDS in 1996, indicated that they had contracted the disease through heterosexual contact.[1]
- Many high school students—both black and white—reported having had sexual intercourse in 1995. A larger percentage of black males (81 percent) than black females (67 percent), but equal shares of white males and white females (nearly half—49 percent), reported having had intercourse.[5]
- Because many youth engage in unprotected sexual intercourse, the risk of HIV infection as a result is high. Among youth surveyed in 1995, condom use during intercourse was not universal. Nearly half (48 percent) of white females and 61 percent of black females reported using condoms during last intercourse, while 58 percent of white males and 72 percent of black males also reported this practice.[5]
- Large majorities of high school youth reported having been taught about HIV infection and AIDS in school. Among females, 88 percent of white and 84 percent of black students reported receiving this instruction; among males, the comparable figures were 87 percent of white and 84 percent of black high school students.[5]

JOINT CENTER FACT SHEET

Deaths

- Since 1992, HIV infection has been the leading cause of death among persons ages 25 to 44. HIV infection surpassed unintentional injuries, heart disease, cancer, suicide, and homicide as a cause of death among men this age over this period.[6]
- HIV infection and its sequelae (opportunistic diseases and AIDS) was the third leading cause of death among black males of all ages and the fifth leading cause of death among black females of all ages in 1995. HIV infection killed 12,875 black males and 4,264 black females in that year.[6]
- Among 25- to 44-year-old black males, 182 deaths per 100,000 in 1995 were due to HIV infection and its sequelae. This was the highest death rate from HIV infection for males of the major racial/ethnic subgroups. Similarly, the 55 deaths per 100,000 black women ages 25 to 44 years in 1995, due to HIV infection, was the highest death rate from HIV infection among women of the major racial/ethnic subpopulations.[6]

Source Notes

1. Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report* 8(2) (1996).
2. "The Changing Face of AIDS," *New York Times*, November 4, 1996, p. A26.
3. Centers for Disease Control and Prevention, *Facts About—Adolescents and HIV/AIDS*, December 1995.
4. Tracey Hooker, *HIV/AIDS Facts to Consider: 1996* (Washington, DC: National Conference of State Legislatures, February 1996).
5. Centers for Disease Control and Prevention, *CDC Surveillance Summaries, Morbidity and Mortality Weekly Report* 45 (September 27, 1996; No. SS-4).
6. National Center for Health Statistics, *Health, United States, 1996–1997 and Injury Chartbook* (Hyattsville, MD: 1997).

Prepared by Wilhelmina A. Leigh, Joint Center for Political and Economic Studies, August 1997

APPENDIX B

FOCUS articles on HIV/AIDS

- Teen AIDS
- AIDS and the Youth of Detroit
- The Faces of AIDS
- Legislating Support for AIDS Prevention
- Shared Lessons on the Combating HIV/AIDS

Teen AIDS

The Joint Center Is Conducting a Series of Forums to Address the Growing Number of Black Youth Who Are Becoming Infected With HIV

by Wilhelmina A. Leigh

Under the auspices of the Centers for Disease Control and Prevention (CDC), the Joint Center for Political and Economic Studies is hosting three forums across the nation to address the issue of the escalating incidence of HIV infection and AIDS, especially among African American adolescents. These events will bring together public officials in three regions of the country to share information about promising initiatives for changing the risky behaviors that make adolescents particularly vulnerable to contracting this deadly virus. The first forum took place in Oakland, California, on June 29. The other two forums will be held in Memphis, Tennessee, and Detroit, Michigan. Dates have not yet been set.

Since the HIV virus was first identified in the early 1980s, HIV infection and AIDS have become major causes of disability and death among various segments of the U.S. population. But especially alarming is the recent dramatic increase in the incidence of infection among adolescents. The result of this early infection has been a precipitous and frightening rise in the numbers of young adults dying from AIDS. In 1992, just a decade after the discovery of the virus, AIDS became the leading cause of death for men ages 25 to 34. It was the fourth leading cause of death among women in that age group.

For both female and male African American adolescents and young adults, the statistics show the same grim reality. From the early '80s, when the virus was first identified, through the end of 1994, nearly 1,800 black males ages 15 to 24 had died from AIDS, but the number of black males between the ages of 24 and 34 who had died from the disease was twelve times higher—a figure approaching 21,700. The numbers for black females showed the same trend, with nearly 800 deaths in the 15-to-24-year-old age group compared to more than eight times that number in the 25-to-34 age group. Considering the usual span of time between infection with HIV to death from AIDS, the young adults who died from the disease most likely contracted it during their teen years. Clearly, the prevention of risky behavior in these crucial years will save many young adults from devastating illnesses and premature death.

The Joint Center forums will allow public officials, community leaders, service providers, and other interested persons to pool their information about initiatives that could be effective in educating adolescents about the risky behaviors that lead to the spread of AIDS. To facilitate this interchange, each forum may include formal presentations by speakers with special knowledge about the impact of AIDS on the adolescent population and informal discussions in which attendees will be invited to share information, questions, and perspectives on this issue.

Oakland Forum Examines Role of Leadership

The first of the three HIV/AIDS forums, held in Oakland and entitled "HIV/AIDS and African American Youth: The Role for Leadership," attracted local officials, community leaders, and service providers throughout the California East Bay area.

Speakers included Oakland Mayor Elihu Harris, who opened the forum; Dr. Milton Morris, vice president for research at the Joint Center; Anita Williams, staffperson to State Assemblywoman Barbara Lee; Carole Flowers, coordinator of special health programs for the Oakland Unified School District (OUSD); and Dr. Robert C. Scott, an Oakland area physician who specializes in internal medicine.

Representing the Joint Center, Milton Morris discussed the role of community leadership in addressing the problem of HIV/AIDS among adolescents. He outlined three major challenges for community leaders: (1) to build bridges among the many diverse groups in the African American community that need to work together on this problem; (2) to build consensus around issues on which most persons can agree instead of becoming stymied by controversial issues that divide communities; and (3) finally, to mobilize communities to combat the spread of HIV/AIDS.

Anita Williams, representing California State Assemblywoman Barbara Lee, discussed leadership at the state level. Specific state efforts to improve HIV/AIDS education include an *HIV Prevention Guide* that has been distributed throughout the state of California and a comic book, featuring "Kid Justice," produced cooperatively with the Oakland Department of Health and Human Services. The comic book, which has been distributed to youth in the East Bay area, is published in English, Spanish, and Chinese. A bill recently introduced in the California Assembly by Lee would mandate AIDS prevention education for youth prisoners. The bill emphasizes the need for peer educators to work with youth in prisons and other institutions to stem the spread of HIV/AIDS among this vulnerable segment of the youth population.

Dr. Leigh is a senior research associate at the Joint Center.

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AIDS

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Speaking for the Oakland Unified School District, Carole Flowers detailed district efforts to implement the state law requiring HIV/AIDS prevention education in middle schools and high schools. Incorporated in the curricula of two required courses, HIV/AIDS prevention education has been offered in the district since the 1992-93 school year. In addition, 34 school nurses in the district are available at the request of classroom teachers to teach sensitive issues. To gain community support for the educational program, Flowers organized and met with advisory committees representing clergy, parents, and community groups to explain the program and to provide details about the specific messages and instructional materials.

Recently, the district has added a peer education component at the high school level. Youths ages 14 to 17 design and produce T-shirts adorned with an HIV prevention message, which they wear when they address youth audiences. These peer educators also have created a "living quilt" with patches that convey messages about ways to avoid HIV infection.

Robert Scott discussed the need for community leaders and service providers to build trust with adolescents in order to reach them with messages about HIV/AIDS. As a doctor of internal medicine in the Oakland area, Scott drew upon his experiences with AIDS patients. He noted a generalized distrust among many African Americans of government public health initiatives and the effect of this distrust on efforts to educate African Americans about the nature and transmission of AIDS. He credited this attitude to past experiments such as the one at Tuskegee Institute in which African American men with syphilis were observed, rather than treated, by government scientists in order to advance medical knowledge about untreated syphilis. Scott also emphasized the need for blunt talk with adolescents about safe sex. He further noted that he stresses to adolescents their obligation to take care of themselves because of their importance to their communities and the society at large.

Art and AIDS

As planned, much of the forum was devoted to the exchange of ideas, suggestions, and information among participants. Leaders from a variety of HIV/AIDS education and prevention programs, community-based organizations, and religious groups discussed their own programs and made suggestions for the development of new efforts.

Joe Hawkins, a community activist and cochair of the local Ryan White Title II consortium, talked about the need to develop leadership in the African American community to provide role models and a support network for gay adolescents. A primary function of this leadership would be to eliminate homophobia, which he believes to be an impediment to the fight against HIV/AIDS in the African American community.

Rev. Mark Wilson of McGee Avenue Baptist Church in Berkeley, California, discussed the need for education and training to eliminate patterns of sexual promiscuity among some members of the clergy that contribute to the spread of AIDS. He echoed the call for special support groups for gay and lesbian African American youth.

The executive director of the AIDS Project of the East Bay, Valerie Papaya Mann, explained her program's use of music, art, and drama as vehicles for HIV/AIDS education for youth. The program recruits artistically talented students and requires them to attend 10 sessions of HIV/AIDS education as a prerequisite for participation in a public display of their creative works. Their March showcase attracted more than 300 students and their parents to an exhibition of student art, music, and dramatic creations focused on the theme of AIDS prevention.

The deputy director of the California Prevention Education Program (CAL PEP), Carla Dillard Smith, described her organization's outreach, research, and intervention programs, which target women 15 to 34 years of age in the East Bay area. CAL PEP also incorporates an HIV/AIDS prevention message into its celebrations of Kwanzaa and Juneteenth (a holiday commemorating June 19, 1865, the date when slaves in Texas learned that they had been freed by Lincoln's Emancipation Proclamation). Smith stressed the need to extend HIV/AIDS prevention education to two groups of African Americans not currently targeted—heterosexual males and members of the middle class.

Flora Krasnovsky, from the Center for AIDS Prevention Studies, spoke of the need to educate parents as well as students. According to Krasnovsky, many of today's parents were teens when they became parents and consequently lack the knowledge base for educating their children about sexuality, generally, and HIV/AIDS prevention, specifically. She urged the funding of programs to provide this needed education for parents.

Facilitator C. Godfrey Jacobs of Hi-Tech International, Inc., an Arlington, Virginia-based consulting company, concluded the forum with the following summary of the principles on which successful HIV/AIDS programs are based:

- Interventions should be culturally based.
- Interventions should use community or school leaders rather than trying to impose external leadership.
- Interventions should emphasize the strengths rather than the weaknesses of youth and capitalize on their interests in such areas as music, drama, and art.
- Sources of information should be located within the community or school.
- Active approaches work better than passive ones; that is, reach out to youth rather than trying to get them to come to you.
- HIV/AIDS education should be combined with other community activities, issues, or efforts, such as programs to combat unemployment, drug use, and teen pregnancy. ■

AIDS and the Youth of Detroit

The Second Joint Center/CDC Forum on AIDS and Young People Exposes Myths and Calls for Church Involvement

by Wilhelmina A. Leigh

When AIDS and its causal agent, the human immunodeficiency virus (HIV) were first identified in the early 1980s, they were perceived as a rarity, found primarily among gay white males ages 35 to 45 living in the major cities on the East and West coasts. Fifteen years later, HIV/AIDS has leapt across the demographic divide. In late 1995, more than half a million cases of AIDS were reported by the Centers for Disease Control and Prevention (CDC), affecting men and women of all ages and races throughout the nation.

AIDS has been spreading with a special ferocity among African Americans in recent years. According to Dr. Peter Gulick, assistant professor in the College of Medicine at Michigan State University, one out of three black men between the ages of 29 and 35 now is thought to be HIV positive. And AIDS is one of the leading causes of death for black women ages 25 to 44. Because the HIV virus can lie dormant for 10 years or more, these and related statistics mean that HIV infection is being contracted by blacks during their teen years.

With this in mind, the CDC funded a series of forums hosted by the Joint Center to address the issue of AIDS especially as it affects African American adolescents. The events bring together local public officials and others in the community to share information about promising initiatives for changing the risky behaviors that make adolescents vulnerable. The first forum, conducted June 29, 1995 in Oakland, California, was featured in the September issue of *FOCUS*. The second, titled, "Health Issues for African American Youth: The Role for Leadership," was held in Detroit, February 12, 1996. A third forum was held in Memphis on March 9.

Organized in collaboration with the Detroit Health Department, this second forum attracted more than 70 leaders—local and state appointed and elected officials, service providers, and community activists. They discussed the ongoing initiatives in Detroit and surrounding communities that address the multiple threats to the health of African American youth of substance abuse, violence, unprotected sexual intercourse, and HIV/AIDS. Two recurring themes during the discussion were the role of prevention education and the role for local leaders in fostering such education.

Risk Born of Hopelessness

The question naturally arises as to why African American youth should be contracting the HIV infection today at rates so much greater than other young people. Dr. Bailus Walker, director of Health Programs at the Joint Center, pointed out that the lack of a vision of a brighter future combined with the youthful urge to experiment can have destructive consequences. This was echoed by several other speakers, including Rev. Renee McCoy, who argued that youth who have nothing to live for simply don't fear dying. Rev. McCoy, a pastor of the Full Truth Unity Fellowship Church in Detroit and a former HIV/AIDS community liaison for the Detroit Health Department, referred to the "brokenness and harshness" of these youths' lives.

That young people are the originators of their own destructive behavior was an assumption questioned by Allen Martin of the Detroit Health Department's Bureau of Substance Abuse. Arguing that HIV/AIDS, violence, and substance abuse result from the high-risk behaviors of adults that have been adopted by youth, Martin suggested that we might get better results if we work on changing the behavior of adults. He acknowledged, however, that one way to do this may be to teach the preferred behavior to youth who can take it home for their parents to emulate.

The need for strong AIDS education was brought out by professionals in the field who have found a surprising level of misinformation among young black men and women. Many youth still believe that HIV infection occurs only among persons who are gay and, therefore, assume that because they are heterosexual, they can abuse intravenous drugs and have unprotected sexual intercourse without risk of infection. Dr. Gulick views correcting this misconception as a major reason to continue AIDS education among youth.

Rev. McCoy noted as well that the cultural outlook of African American youth often differs markedly from that of the adult experts who prepare prevention messages. For example, African Americans generally may not appreciate the distinction between condom use for contraception and for protection from disease. Those who believe, as do some nationalists, that pregnancy prevention programs targeting blacks have genocide as their goal, may dismiss efforts to encourage condom use.

Another myth explains the AIDS epidemic itself as a form of germ warfare being waged against racial/ethnic minorities by the dominant society. Researchers still do not know exactly how the HIV virus originated or first entered humans—just as they still do not know the origins of so many major diseases. Yet James Knox, a person with AIDS who works for the Wayne County Neighborhood Legal

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AIDS in Detroit

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Services AIDS Law Center, noted that this was the question he encountered most often when speaking to students.

Several speakers were skeptical that scientific explanations could ever quell teens' fears of a conspiracy. Yet, without some basic trust in medical and governmental authorities, young people may remain unresponsive to sound prevention advice. Constance Rowley, of the Southeastern Michigan HIV/AIDS Council, admitted that she deals with the "origin" question by ignoring it in order to focus attention on useful preventive information.

Some voices at the forum were optimistic about the value of education in helping to save lives. Dr. Margaret L. Betts, vice president of the Detroit Board of Education, credited education and consequent changes in behavior with the decline in new cases of HIV among gay white males and suggested that it could be equally effective among African Americans.

While the open discussion of AIDS prevention in school classrooms remains controversial in many communities, a recent Gallup survey shows broad support for including the subject in the curriculum. Dr. Betts cited a survey that found that 79 percent of adolescents consider comprehensive school health instruction as important as other subjects taught in the schools. Perhaps more important for school boards and school politics, the survey found that 92 percent of parents consider HIV/AIDS prevention education to be as important as, or more important than, other school subjects.

Partnerships for Youth AIDS Awareness

Guided by the Michigan model of a hands-on, materials-oriented program to deliver comprehensive school health instruction and services to children throughout the state, the Detroit school system has developed a health program with eight components, including health education and health services. The system requires that 10th graders take a course for personal health management that covers disease prevention and control, substance use and abuse, human sexuality, violence prevention, fitness, stress management, emotional and mental health, and nutrition.

Given current attacks on similar education programs, the Detroit comprehensive health program is at risk of cancellation. But David L. Snead, general superintendent of the Detroit Public Schools, stated that the system will continue to rely on partnerships with local hospitals and clinics to help these initiatives stay alive. Other partnerships have been essential as well. In one of the city's vocational high schools, the Red Cross trains youth to be peer educators about HIV/AIDS; these youths then share their prevention message with students at other schools. Other valued partners include the Kellogg Foundation, which funds health centers in 13 city schools and several of the city's medical facilities.

Forum participants spoke of ways in which they felt that school curriculums need to be supplemented or re-oriented. Dr. Gulick stated that while youth must be told that condom use can be effective in blocking the virus, they must also know that the only behavior guaranteed to avoid HIV transmission is sexual abstinence.

Jerome Boyce, a person with AIDS, suggested that as it is currently structured the health curriculum in the Detroit school system does not yet allow the breadth of discussion needed to prevent HIV/AIDS among youth. In his view, a dialogue needs to be encouraged on the subject of human sexuality in all its varied expressions. Boyce believes young people want this type of discussion and, indeed, need it to be able to deal with sensitive issues such as persuading partners to wear condoms.

Expanding the Partnership

But the business of AIDS prevention cannot be left for the schools to bear alone. Dr. Bailus Walker pointed out that since the health needs of youth are systemic, reaching beyond substance abuse and HIV infection, initiatives to meet these needs can only be successful if they expand partnerships to include not only schools, but also churches and social service agencies. Detroit Mayor Dennis Archer, who opened the forum, cited the challenge to leadership to develop creative community responses to the overlapping problems of substance abuse and HIV infection.

Rev. Renee McCoy emphasized the role churches can play. To reach youth and change the high-risk behaviors responsible for health problems such as AIDS, churches must "come out of the scriptures and live the gospel," she said. More specifically, she identified three areas where churches can contribute to the effort. First, Rev. McCoy believes churches need to help make their communities safe for children. Many youths today find the peer pressure against positive behavior more than they are willing or able to bear. Making communities safe, she argued, means churches must battle the drug dealers who have won the allegiance of youths, even if those drug dealers "are our blood relatives."

Second, communities of faith should provide places where youth can talk to one another and to adults, filling the role that dope houses currently fill for too many youth. In Rev. McCoy's view, establishing dialogue to let youths know that adults feel good about them and to help youths feel good about themselves is the first step toward changing high-risk behavior. Third, churches should teach parents about childrearing. She argued that churches can be instrumental in giving both parents and their children a vision that is larger than their immediate environment, making it possible for youths to look forward to long, productive lives, favoring life over death.

While churches have an essential role to play in educating young people about HIV/AIDS, the Detroit conference demonstrates that success in preventing the spread of this scourge among youth will require multiple strategies involving a variety of community-based institutions. Those taking part in these efforts must be prepared to make a long-term commitment to addressing this fatal and yet incurable disease that has taken hold in America's black communities. ■

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The Faces of AIDS

The Third Joint Center/CDC Forum on AIDS Shows the Human Face of the Disease and Searches for a Community-Based Action Agenda

by Wilhelmina A. Leigh

In Tennessee, like the rest of the nation, African Americans contract the human immunodeficiency virus (HIV) and AIDS at a rate far higher than that of the general population. Although blacks constitute only 16 percent of the Tennessee population, they make up 35 percent of all AIDS cases and 61 percent of the cases of HIV infection reported in the state since the discovery of the disease in the early 1980s. Teens represent more than 4 percent of the reported cases of HIV infection, but more than three-quarters of HIV-infected teens are African Americans.

Leading the state in reported cases of HIV infection and AIDS is the Memphis/Shelby County area. According to Yvonne Smith Madlock, director of the Memphis and Shelby County Health Department, as of December 1995, 1,900 persons in these jurisdictions had been diagnosed with AIDS, and an additional 2,100 persons had been diagnosed as HIV positive.

On March 9, 1996, Memphis was the site of the third HIV/AIDS prevention education forum hosted by the Joint Center for Political and Economic Studies, with funding from the Centers for Disease Control and Prevention (CDC). The two previous forums were held in Oakland, California, and Detroit, Michigan. (See *FOCUS* issues September 1995 and April 1996.) Entitled "HIV/AIDS Among African American Youth: Developing An Action Agenda for Leaders and Policymakers," this forum was organized to develop a comprehensive approach to reducing the incidence of HIV/AIDS in the City of Memphis and Shelby County.

State Representative Kathryn I. Bowers, who represents a district in Memphis, chaired the forum coordinating committee. The Memphis and Shelby County Health Department assisted with planning the half-day forum, held in conjunction with a conference on HIV/AIDS education and leadership for pastors sponsored by the African American Church Consortium. More than 75 state and local elected officials, policy makers, religious leaders, service providers, and persons with AIDS gathered at the Mississippi Boulevard Christian Church for the event.

The Faces of AIDS

Titled "The Faces of AIDS," the most poignant segment of the forum involved a panel made up of AIDS victims and those who support them. These faces included two teenage mothers and a formerly incarcerated gay man—"Jane," "Mary," and "John Doe,"—and Novella Smith Arnold, head of We Care, Inc., a criminal justice ministry with more 500 volunteers. Arnold, a licensed chaplain and a candidate for ordination in the Episcopal Church, counsels young people and prisoners with AIDS. The two young women, both teen mothers with AIDS, have been abandoned by their families. Eighteen-year-old Jane Doe's mother put her and her two-year-old son out of the house after Jane was diagnosed as HIV positive. Sixteen-year-old Mary Doe, in the dementia stage of AIDS, was forced to leave home by her mother, a recovering intravenous drug user, who expressed fear of catching the disease from her daughter.

Jane had heard of AIDS, but thought it was a gay disease that she could not get through a heterosexual encounter. Mary had received no education about HIV/AIDS either at school or at home. It never occurred to her that she could contract the disease. Chaplain Arnold says both teenagers had been taken advantage of by older men (one 28, the other 35), and they were unaware of the risks involved with the sexual encounters with the men. Jane's message to other teens is: "the safest sex is no sex."

Arnold, whose daughter also is suffering from AIDS in its latter and most devastating stages, condemns the way AIDS victims are treated by their families and communities. She said: "AIDS is the most deadly killer in our inner cities, but we know so little about it. And I'm appalled that a family would kick their own children out of their homes. Even dogs and cats take care of their sick." Neither Jane nor Mary have permanent homes and must seek temporary shelter with various relatives. Arnold has made a plea to residents of Memphis and Shelby County, who have extra bedrooms, to open their homes to young people who find themselves homeless as a result of their diagnoses with the HIV infection or AIDS. The final face of AIDS was "John Doe," a thirty-year-old gay man. As a cross-dressing homosexual, John was a target of sexual assault while in prison. During his incarceration, he was infected with HIV as a result of being raped. Chaplain Arnold noted that because homosexual men in the local jail—many of whom are HIV positive—are no longer segregated from other men, sexual activity, both forcible and voluntary, has created an HIV/AIDS epidemic there. Sex-for-drugs exchanges also contribute to the spread of HIV infection within the correctional system. Often without knowing they are infected, men, when released from jail, transmit HIV to their wives, girlfriends, and partners.

HIV/AIDS testing at the jail is voluntary, said Arnold, and inmates usually must make repeated requests and

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frequently must call upon outside advocates in order to be tested. Thus, there is no established means of screening and no effort to separate prisoners to stem the epidemic. Both Chaplain Arnold and John Doe made a plea to the legislators attending the forum to make condoms available at the jail and to advocate mandatory education and testing for HIV/AIDS to reduce the incidence of the disease within Memphis and Shelby County. Because of her participation in the forum, however, the Shelby County Sheriff's Department has banned Chaplain Arnold from the county jail, the site where she had been counselling since the facility opened in 1981.

Dr. Craig Dorko has treated many HIV/AIDS patients in the Adult Special Care Clinic at the "Med" (University of Tennessee Regional Medical Center at Memphis) over the past six years. He spoke about the factors that contribute to the high rates of HIV infection and AIDS in Memphis and Shelby County. The high incidence of drug-resistant gonorrhea and other sexually transmitted diseases, he noted, are evidence both of unprotected sex and of a heterosexual population among which HIV/AIDS is likely to spread quickly.

Teaching Parents to Teach Sexuality

The "Faces" panel evoked a strong response from forum participants. A teen in the audience asked how one can effectively tell teens not to have sex, when so many teens use sex to bolster their self-esteem or to procure money and material possessions they might not otherwise have. Dr. Dorko admitted that it is difficult but necessary to make this point with teens, especially in light of the fact that condoms are not 100 percent effective. Since many young people believe that condoms guarantee safe sex, he recommends having peers educate other teens about issues and risks related to sexual activity.

In the discussion related to HIV prevention education, another Memphis teenager who attends a public high school noted that the curriculum on health and sex education that is supposed to be in place for the kindergarten through 12th grade has not been implemented at any of the schools she has attended. Commissioner TaJuan Stout Mitchell of the Memphis Board of Education noted that a recent national survey of youths asked what could be done to improve health education in the schools. Many of the respondents suggested that if parents don't want schools to teach family life and sexuality, the schools should offer classes for parents, because the youths fear that there is no other way for them to be informed about the disease.

Another youth proposed that teachers become adequately informed and feel comfortable addressing the issues, so students will also feel comfortable and gain the greatest benefit from the instruction. Others advocated creating peer-counseling groups and making literature about all health-related issues and targeted to youth available in the schools. A final survey recommendation was to let children organize awareness clubs to promote "No Sex—No Risk" and "Protected Sex—Less Risk."

Mitchell remarked that the only current vaccine available to combat AIDS is education, and this educational vaccine needs to be strong to counteract the current trends in behaviors that contribute to the spread of HIV infection. For instance, on any given day in the United States, 7,742 youths become sexually active; 1,293 give birth; and 675 get syphilis or gonorrhea.

Mitchell suggested that the Memphis City School system offer its students a comprehensive health program that includes education, promotion of health issues, and health services. To be effective, she said such a program should be supported with sufficient resources and personnel, be made easily accessible to students, and not be provided only in response to crises.

HIV/AIDS education not only helps to reduce the misinformation, fear, and denial that limit the effectiveness of prevention activities, but it can also foster sensitivity and compassion, which could lessen the stigma against people diagnosed with the disease. In combination with HIV/AIDS prevention education, a comprehensive school health policy would enable the Memphis system to respond to psychological trauma among children whose parents or siblings die of AIDS.

Reverend T. O'Neal Crivens, of the Testament of Hope Community Baptist Church, suggested that many people are unwilling to get tested for HIV infection because of the close association of an HIV-positive diagnosis with death and society's unwillingness to deal with issues of death and dying. Counseling and education on the broader topic of dying could have benefits in the area of HIV prevention

Recommendations

Toward the end of the forum, participants met in three working groups—community, education, and churches—to develop a list of recommendations to be undertaken to reduce the incidence of HIV/AIDS in Memphis and Shelby County. State Rep. Kathryn I. Bowers and the other elected officials in attendance have taken these recommendations back to the state legislature to address the HIV/AIDS epidemic in Tennessee:

- Strengthen school health programs and put in place a mechanism to measure their effectiveness;
- Support legislation to investigate and prosecute rape of teenage and young adult women by older men, and establish a system for holding these men accountable, financially and legally, for the consequences of their behavior;
- Develop an intergenerational educational curriculum on AIDS awareness for churches, with modules for preschoolers through golden-agers;
- Mandate HIV/AIDS testing for prison inmates and give HIV-positive prisoners the option to be separated from others in the facility; and
- Prepare persons with AIDS to deal with end-of-life issues, from practical arrangements to spiritual/psychological preparedness for death. ■

Legislating Support for AIDS Prevention

A Joint Center Forum in Durham Calls on Elected Officials to Pass New Laws to Help Fight AIDS Among Black Youth

by Wilhelmina A. Leigh

Despite a decline in the U.S. death rate from AIDS in 1996 for the first time since public health surveillance of the disease began in 1981, HIV infection and AIDS continues to spread in North Carolina. And black North Carolinians are disproportionately victims of the deadly virus. As part of an ongoing program to address this concern, the Joint Center hosted its fourth HIV/AIDS prevention forum in Durham, North Carolina, in October 1997—which was both AIDS Awareness Month and "Let's Talk (with Teens About Sex)" Month.

Entitled "HIV/AIDS and African American Youth in North Carolina: The Role of Leadership," the forum attracted more than 170 federal, state, and local officials, representatives from religious organizations, and community activists from across the state. Like those conducted in 1995 and 1996 in Detroit, Memphis, and Oakland, this forum was funded by the Centers for Disease Control and Prevention (CDC). It was organized with the assistance of a local liaison committee chaired by Dr. Elaine Hart-Brothers of the Metropolitan Durham Medical Group and co-chaired by North Carolina State Senator Jeanne H. Lucas.

While African Americans constitute 22 percent of North Carolina's population, they account for 63 percent of the nearly 7,600 cases of AIDS that were reported in the state between 1981 and June 30, 1997. During the first half of 1997, African Americans accounted for nearly three-fourths of all AIDS cases reported in North Carolina among adults and adolescents age 13 and older—comprising, for example, 73 percent of the AIDS cases in Durham County, 59 percent of the cases in Wake County, and 41 percent of the cases in Orange County. State Representative Thomas E. Wright, a panelist at the forum, noted that HIV/AIDS was a leading cause of death among blacks in 1996 in Durham and other counties in the state.

Forum participants pointed out that the "faces of AIDS" are changing, with women and teenagers now the fastest growing groups of newly infected persons. While AIDS was once perceived as a disease contracted by white homosexuals, community leaders are becoming more and more aware that the disease may be contracted by anyone, regardless of race, gender, or age. Jacqueline S. Clements, a forum panelist who is a pre- and post-test HIV/AIDS counselor of youth at Lincoln Community Health Center in Durham, notes that "The face of AIDS that used to be white, gay, and male, today may be an 18-year-old, heterosexual, black college student." A pregnant teenager is now just as likely to become infected with HIV as a female prostitute. As a result, it is becoming harder to ignore the disease, its related social consequences, and the real people behind the statistics.

As HIV infection and AIDS has spread to all segments of the population in North Carolina, community leaders have urged elected officials in the state to pass legislation to address the needs of young people and other groups at high risk of infection. Forum participants discussed three areas in which legislative initiatives have been introduced in the North Carolina General Assembly—comprehensive health education, a needle exchange pilot program, and state funding for the HIV/AIDS prevention activities of community-based organizations.

Comprehensive Health Education

Under a law passed by the North Carolina Assembly in 1995, health education related to sexuality is limited to instruction about abstinence, except in jurisdictions where parents have indicated at local school board hearings that they want broader sex education for their children. The consensus of forum participants was that a statewide health education curriculum should be comprehensive and address a full range of topics, including abstinence, general family health, contraception, HIV/AIDS and other sexually transmitted diseases, abortion, adoption, and hygiene. Eddie Davis III, a member of the North Carolina Board of Education and a teacher at Durham's Hillside High School, noted that it is critical for people who favor comprehensive health education to show up at school board hearings and make their views known. Lavonia Allison of the Durham Committee on the Affairs of Black People suggested that more African Americans run for seats on local school boards throughout the state in order to ensure that these hearings are held and that the interests of black North Carolinians are represented.

AIDS counselor Jacqueline Clements said that an essential part of arming children to resist high-risk behaviors is to teach them first that they are special. We need also to teach—not preach—abstinence and how to abstain. We need to teach teens what to say and what to do when confronted with "If you love me, you'll do it." She added that those who choose not to abstain must be taught how to protect themselves.

Numerous speakers, including Durham School Board member Beverly Washington Jones, supported the need for peer educators or "youth ambassadors" to convey health-risk-avoidance messages effectively to other young people, including gang leaders and drug dealers. Others spoke of the importance of educating parents and clergy in addition to

Dr. Leigh is a senior research associate at the Joint Center.

AIDS

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youth themselves. Sharon Vann, a health educator, felt strongly that health education about sexuality should take place not only in schools but also in churches and at other social and civic institutions.

Needle Exchange Programs

Legislation was recently introduced (but not passed) in both houses of the Assembly that would have established up to four pilot needle exchange programs around the state. This measure would have also mandated that the needle exchange programs periodically provide data to the state Department of Health and Human Services for evaluation of their effectiveness. State Senator Jeanne Lucas noted that several scientific studies have shown that needle exchange programs lessen the risk of infection with HIV and do not increase substance abuse. In fact, needle exchange programs may reduce the use of injected drugs because regular contact with counselors at needle exchange sites encourages some addicts to seek treatment. Since use of injected drugs is implicated in the heterosexual transmission of HIV infection, needle exchange programs have great potential to slow transmission during the current phase of the epidemic.

In addition to Senator Lucas, Representative Wright, and the other members of the Black Caucus of the North Carolina General Assembly, state health director Ron Levine has indicated publicly that he would support a needle exchange program in the state. Bill Newkirk of the North Carolina Education Association, who is a Baptist minister, told the audience that he changed from being an opponent to being a proponent of needle exchange programs as a result of the forum discussion. Newkirk subsequently asked the audience for suggestions on how to better educate other ministers about the issue.

Community-Based HIV Prevention

Legislation to appropriate funds to increase community-based efforts for AIDS prevention was also introduced (but not passed) in the Assembly. This legislation would have provided $1 million to enhance the prevention efforts of both existing community-based organizations and local health departments ($300,000 for each), and would establish new community-based organizations to provide outreach and referral services for persons at risk of HIV infection ($400,000). Kat Turner, with Project StraighTalk of the Durham County Health Department, noted that these would be the first funds from the state of North Carolina to be used for HIV prevention. Jacqueline Clements mentioned two exemplary community-based organizations with youth outreach efforts that could benefit from this legislation—Teens Against AIDS at St. Augustine College in Raleigh and The Adolescent Connection in Greensboro.

At the end of the forum, consensus statements on these three issues were voted on. Approval for each statement was nearly unanimous, and forum attendees volunteered to duplicate and distribute the statements in their communities to generate greater support. This effort would also extend to local elected officials in order to educate them on the concerns discussed at the forum so that they might be pushed in the General Assembly and city councils as legislative proposals.

In his forum presentation, Representative Wright mentioned the possibility of a future in which the only African Americans remaining were the elderly and children orphaned by AIDS. The attendees at this fourth Joint Center forum on HIV/AIDS education pledged to work to prevent such a horrific future. ■

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Shared Lessons on Combating HIV/AIDS

Fighting HIV/AIDS Among African American Youth Requires Prevention, Testing and Treatment, and Money

by Wilhelmina A. Leigh

African American youth are disproportionately affected by both HIV infection and AIDS. Although only 15 percent of the population ages 13 to 19, black non-Hispanic youth accounted for 66 percent of the cases of HIV infection and 48 percent of the AIDS cases diagnosed among this group between 1981 and June 1998. With no cure in sight, it becomes important to arm youth with knowledge that can limit high-risk behavior and disease exposure.

Toward this end, since 1994 the Joint Center for Political and Economic Studies has hosted forums to encourage the support of black public officials and community leaders for HIV/AIDS prevention education. The forums held in Oakland, California (1995), Detroit, Michigan (1996), Memphis, Tennessee (1996), and Durham, North Carolina (1997) made clear how complex providing effective education on this topic to African American youth really is. In February 1999, the Joint Center convened selected participants from the four forums to assess the five-year project and discuss the lessons learned. Discussions centered on prevention education, testing and treatment, and funding needs.

Preventing High-Risk Behaviors

The prerequisites for effectively educating youth about the prevention of HIV/AIDS were generally agreed to be the following: including parents at every step; enhancing the skills and comfort levels of teachers; and making messages available in multiple venues. Parental involvement is critical, since parents can be natural teachers. Although HIV/AIDS-related instruction may be necessary for some parents before they can assume this vital role, the cost of such training was deemed worth it.

One group viewed as pivotal in implementing HIV prevention education is "voting parents of students within a school system." Because school systems are usually evaluated on their math and reading scores, making the case for HIV/AIDS prevention education within an underperforming system can be challenging. Nevertheless, if concerned parents and other like-minded adults—such as health educators and providers—work together to outline what they want youth to be taught, they can be instrumental in moving school boards to action.

Another key component in effective prevention education is having a cadre of trained teachers who are comfortable offering such instruction to youth. Training can enhance the comfort level of the teachers of biology, social studies, or physical education who are often assigned to provide HIV/AIDS instruction but who may be ill at ease when discussing sexuality with teens. Parents and other community members can help by letting school boards know that they support the spending needed to train teachers to offer this potentially life-saving instruction.

School-based health programs, although sometimes limited in the type of instruction or demonstrations they can offer, are one potentially valuable venue of instruction. Durham, Memphis, and Oakland offer another model for in-school instruction. Upon request from classroom teachers (and with parental permission), staff from community-based organizations and health educators unaffiliated with these school systems often provide instruction within local schools.

Although schools are a logical place for providing instruction, whether they are the best place in which to teach teens how to avoid becoming HIV positive was debated. If youth already engage in high-risk behaviors, one participant noted, then they need not only information about condoms but also the knowledge to enable them to incorporate condom use into their lifestyles and behavior. Even if the basic information can be imparted in school, she doubted whether the knowledge necessary to change behavior and lifestyles could be. In short, instruction on ways to avoid HIV infection should be provided using multiple messages in multiple venues, including outside of school.

Ways mentioned to reach students during their out-of-school hours included a weekend retreat for teenage girls at which sexuality issues were aired extensively. Taking youth out of their normal environments can enhance the flow of information and range of issues discussed. School-based after-school programs also have been used. Although after-school programs may provide opportunities to convey messages that could not be provided during school hours, forum participants were uncertain whether the rules that govern school-time programs also would apply to after-school instruction and, thereby, limit its flexibility and advantages.

Participants felt that an impediment to putting prevention education into practice in schools is the way AIDS-related issues are covered by the media. Media emphasis on declining death rates from the disease was criticized

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Combating HIV/AIDS

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because it minimizes the urgency of the need for prevention education. This media focus was blamed as a source of difficulties in sustaining people's interest in the epidemic, implementing prevention education in places that have none (or that have only fledgling programs), and mounting vigorous education campaigns among the people now most affected (e.g., people of color, women).

Testing and Needle Exchange

Part of becoming educated about HIV/AIDS is learning one's status as a result of being tested. In both Detroit and Oakland, to reach youth and others who may be reluctant to learn their HIV status, testing is made available via a mobile clinic. In Durham, testing is offered from a van that operates on a circuit through high-risk communities, a project supported by a community-based organization and the local health department. In Memphis, several churches provide HIV testing on their premises for persons who may be unwilling or unable to go to the Memphis-Shelby County Health Department (which collaborates with the churches on this initiative) for this purpose.

Testing the noninstitutionalized population comes with one set of challenges; testing the incarcerated population comes with another. In Tennessee, a major concern is the spread of HIV infection as the result of incarceration, both among inmates and among the sexual partners of former prisoners. Legislation was passed requiring HIV testing of all persons under age 21 convicted of a crime and sentenced to a state prison. Although this recently passed law may help limit the spread of HIV infection, the unwillingness of the state to distribute condoms in all prison facilities will diminish its effectiveness. Condoms are distributed within the Tennessee prison system only in facilities that allow conjugal visits.

Needle exchange also was discussed, as a form of harm reduction and as a means for substance abusers to get treatment for their addictions as well as testing and treatment for HIV infection. Privately funded needle exchange programs operate in both Detroit and Oakland. Neither Durham nor Memphis has a needle exchange program, although community-based organizations in Durham distribute bleach kits to substance abusers.

The needle exchange program in Oakland has operated for four years. Although needle exchange is illegal in Alameda County, where Oakland is located, the program survives because local police and sheriffs honor an unwritten agreement to "look the other way." The three-year-old Detroit needle exchange program is legal, having been implemented after a thoughtfully orchestrated campaign to win community support. Detroit Health Department staff met with all concerned parties (e.g., clergy, law enforcement officials, and the general public) to garner the support necessary to persuade the city council to change the existing statutes. Clients of Detroit's program can get health and hygiene kits from the needle exchange facilities and can get referrals to treatment for substance abuse, HIV infection, and other conditions.

Competing for Money

All site participants reported that funding to meet the unmet and changing needs of African Americans affected by HIV/AIDS was in short supply. The Detroit Health Department had applied for but had not received funding to evaluate its needle exchange program. The executive director of an HIV/AIDS management and service organization in Durham also works full time as a nurse since her organization's limited funding does not allow her to be salaried. Although President Clinton, at the urging of the Congressional Black Caucus in 1998, set aside funds to address issues related to minorities with HIV/AIDS, participants questioned where this money has been channeled and how it has been disbursed.

There was a generalized frustration at the prospect that the allocation of federal dollars for HIV/AIDS would only offer more "business as usual," that is, with two problems likely to persist. First, AIDS dollars would continue to go to service organizations established to work with gay males, even though the funds are now earmarked for populations that these organizations may be culturally incompetent to serve. Second, many African American community-based organizations would lose out in the competition for funds, not because their programs are ineffective, but because their programs have not been evaluated or because their record-keeping is sub par.

Oakland provides an unusual example of steps taken in the hopes of procuring funds. In November 1998, at the request of community-based organizations, the Alameda County Board of Supervisors and U.S. Representative Barbara Lee (who represents Oakland) declared a state of emergency with respect to the growing rate of AIDS among African Americans in this jurisdiction. Although the declaration does not guarantee additional public or private funding for any entities, Oakland organizations supported it as a means of enhancing the likelihood of funding for service organizations in Alameda County, raising community awareness, altering public policy development, and improving the continuum of care made available to persons with HIV/AIDS.

Learning From Each Other

The Joint Center's project provided the means for community members to air their concerns about prevention education for African American youth and for black public officials and community-based organizations already working on HIV/AIDS prevention to share their knowledge. Although Detroit, Durham, Memphis, and Oakland vary in the policies and politics governing their approaches to preventing the spread of this disease, people from the four sites were able to learn from and teach one another. As efforts to limit the spread of infection among African American youth continue, black public officials and community-based organizations in these and other locations undoubtedly will play vital roles. ■

APPENDIX C

Evaluation Form From the Durham Forum

JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES

HIV/AIDS IN AFRICAN-AMERICAN YOUTH IN NORTH CAROLINA: THE ROLE OF LEADERSHIP
Durham, NC

EVALUATION FORM

1. What was your primary reason for attending this forum? (Check only one response)

To learn about school-based implementation issues ☐

To enhance my involvement in the community ☐

To obtain information about program implementation/funding ☐

Other ☐

Comments: _____

_____

_____

2. Please let us know how useful different information was for you.

	Very Useful	Somewhat Useful	Not Useful
HIV/AIDS: Perspectives on Infected Youth	☐	☐	☐
HIV/AIDS: Education	☐	☐	☐
HIV/AIDS: The NC General Assembly	☐	☐	☐
Development of Action Agenda	☐	☐	☐

Comments: _____

_____

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3. What next steps do you think should be taken to lessen the incidence of HIV/AIDS among African-American youth in North Carolina? **(Rank in importance, from 1=Very Important to 5=Not Very Important)**

Form an on-going discussion group with forum attendees and other interested persons _____

Provide information on existing programs/initiatives to local officials and policy makers _____

Support initiatives on related issues (e.g., teen pregnancy) _____

Form an action group to influence program implementation in schools _____

Other(s): (Please List) _____

_____

_____

_____

4. Would you be willing to participate in and work with the group?

Yes☐ No☐

If "Yes," how would you like to participate? What role do you see yourself performing?

_____

_____

_____

5. What specific steps do you foresee undertaking within the next six months to enhance HIV/AIDS prevention education in your locality (and thereby slow the spread of the epidemic)?

_____

_____

_____

6. In what sector do you work? **(Check the one that best describes your organization)**

Business	☐	Education	☐
Labor Organization	☐	Community-based Organization	☐
Hospital/Medical Institution	☐	Other Non-profit	☐

Other: (Specify) _____

7. Name and Contact Information

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